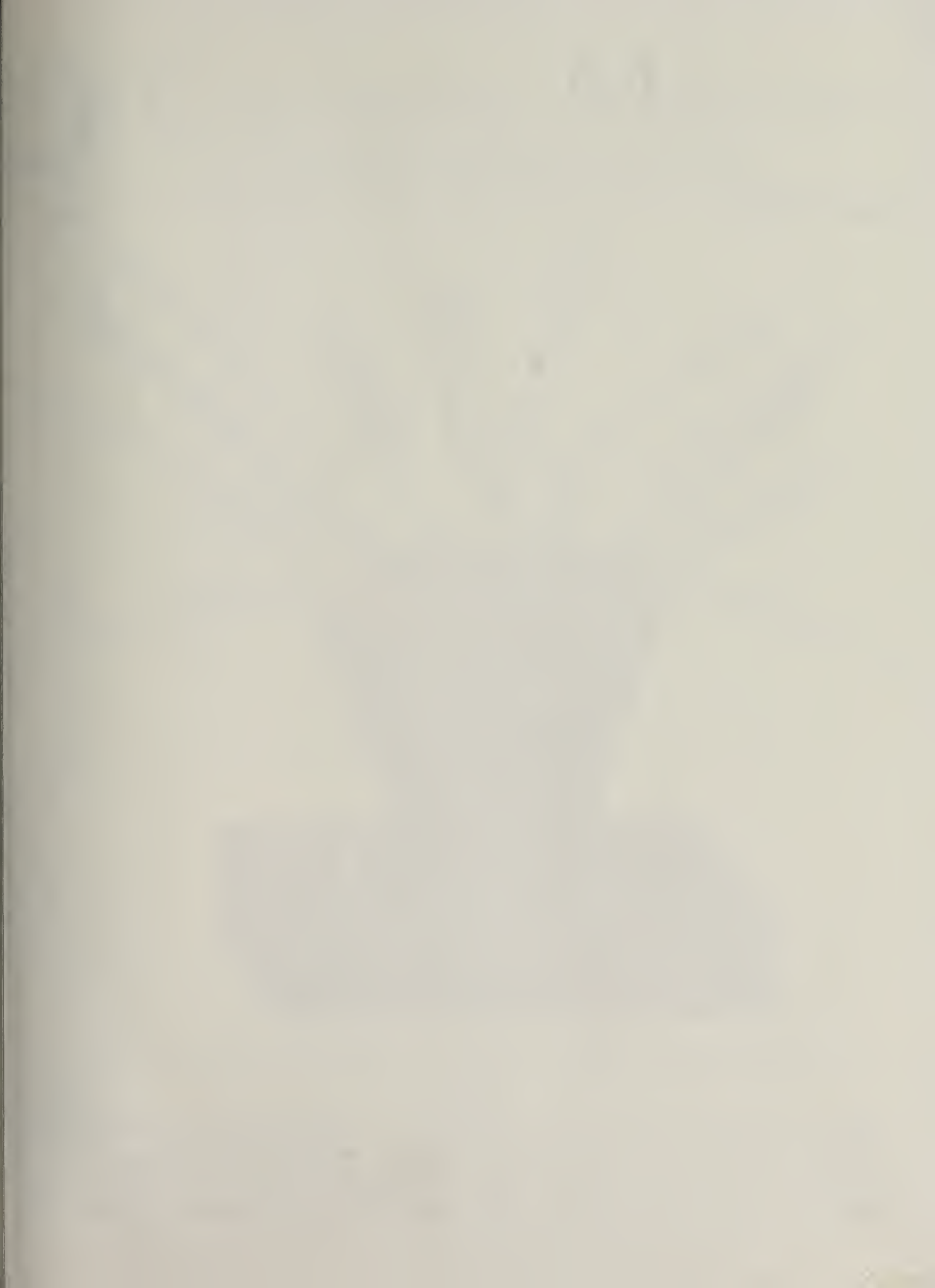
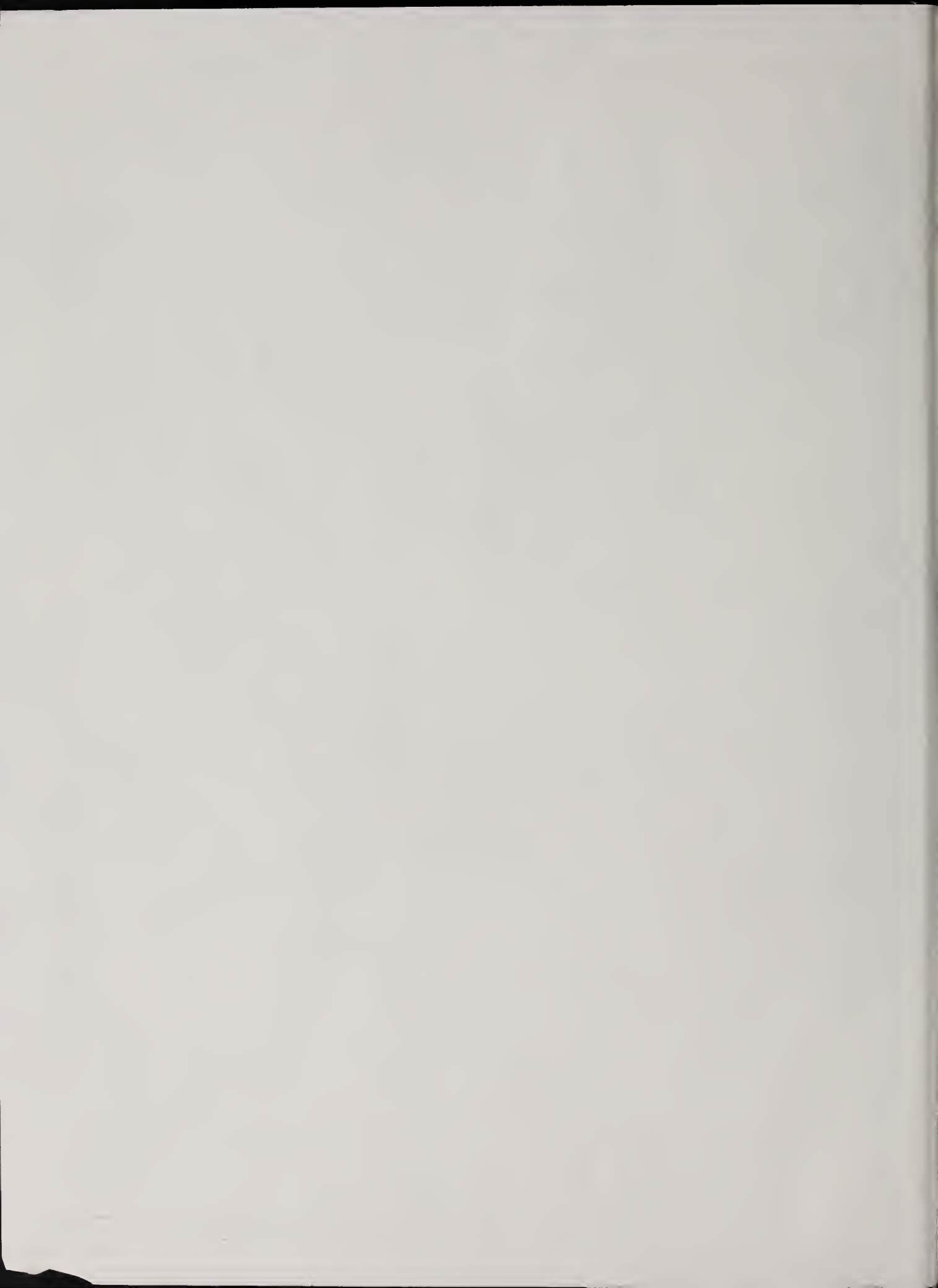
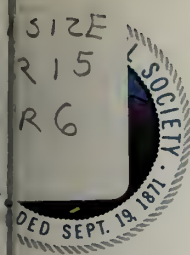








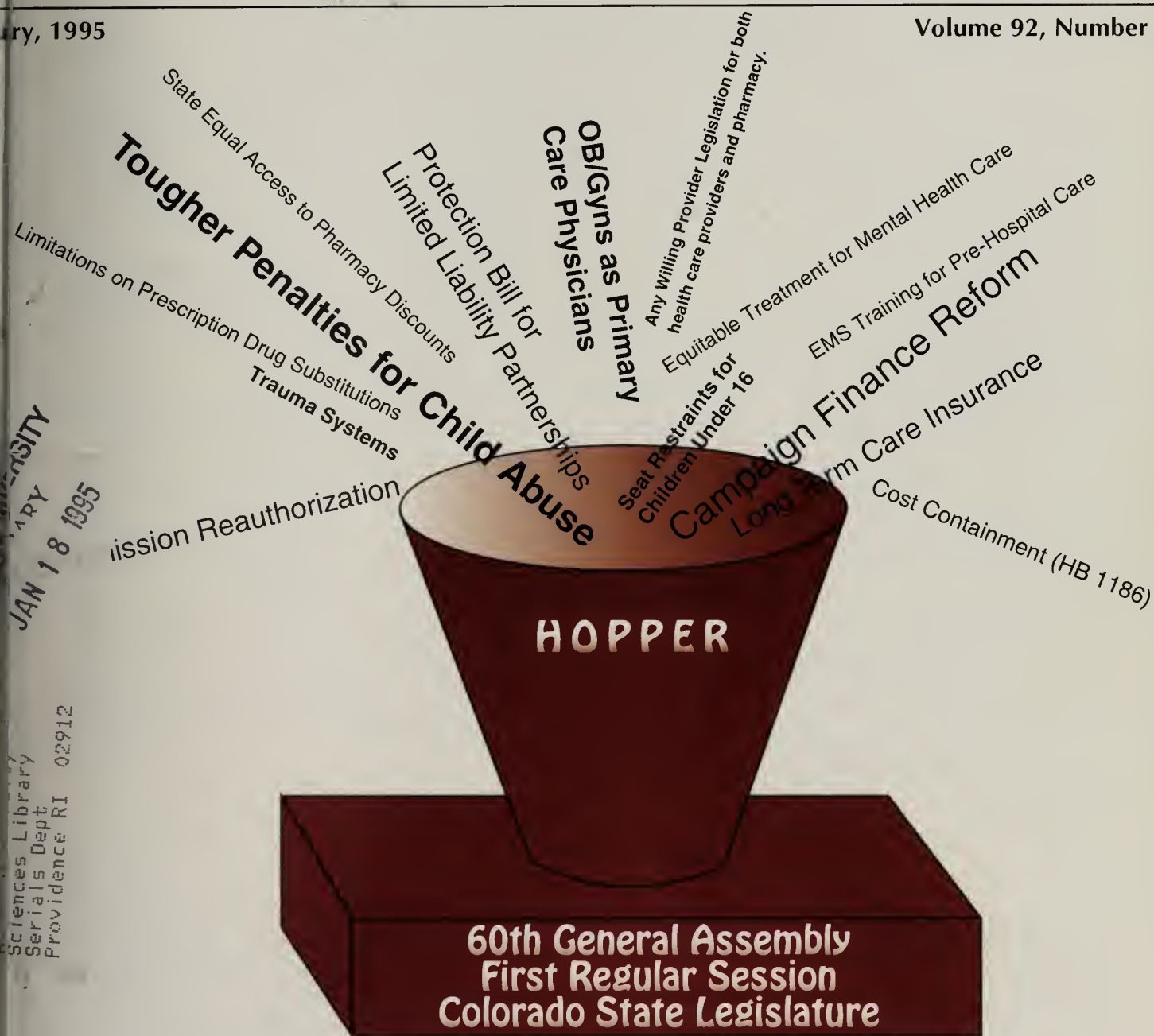


COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

January, 1995

Volume 92, Number 1



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You spent over
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COLORADO MEDICINE

January, 1995

Volume 92, Number 1

A Bill for An Act

Cover Story

Many different items will go into the Legislative hopper when the session opens January 9. Only a few will survive and they will change often before they become law. Check page 12.

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- 1. The Choice is Yours—for Patients**
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Surveys show physicians and their patients need more information on Living Wills, Medical Durable Power of Attorney and CPR Directives. What are they? How do they differ? Where can the forms be obtained?

A consortium formed to answer those questions has produced these two companion videos. One is targeted toward patients, their families, medical support staff, clergy, attorneys, the general public and others who need general information. The other is specific to physicians and other health care professionals.

The videos are available for \$25 each from the Colorado Springs Osteopathic Foundation, Health Resource Center, The Penrose-St. Francis Healthcare System, PO Box 7021, Colorado Springs, CO 80933.

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...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax®
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

Medicare Cuts Would Reduce Access

ASIM Questions Kerrey/Danforth Plan

The American Society of Internal Medicine (ASIM) has issued a statement raising concerns about a proposed cut in Medicare payments for physician services. According to the ASIM statement, Senators Bob Kerrey (D-Neb.) and John Danforth (R-Mo.) made recommendations for the cuts as chairs of the Bipartisan Commission on Entitlements and Tax Reform. However, ASIM says the two senators are operating under incorrect assumptions.

First, the statement says, the senators seem to be under the impression that slashing physician fees will not affect access to medical care. Current Medicare rates pay less than two-thirds of what private insurers pay and the Physician Payment Review Commission (PPRC, the government's own fee researcher) estimates that the proposed cuts could drop Medicare rates to 43 cents on the dollar, lower even than Medicaid.

These lower reimbursement rates could easily force physicians to stop seeing Medicare patients because they could no longer afford to provide services. Many physicians are already forced to limit the number of Medicare and Medicaid patients they see because the lower rates are subsidized by other patients in the practice. Cutting the rates even further would inevitably lead to reduced access to medical care by elderly people.

The other faulty assumption attacked by ASIM was that physician fees have been the beneficiaries of medical inflation. In fact, 42 percent of the reductions Congress has mandated in the Medicare program have been taken from physician fees, though they constitute only 23 percent of Medicare expenditures. According to the PPRC, physician payments increased only 1.4 percent in 1993, half the rate of the Consumer Price

Index and far below all other Medicare categories.

According to the ASIM statement, the Bipartisan Commission is putting the burden of expenditure cuts on the backs of the physicians, who have been the most fiscally responsible part of the program, and if they are successful, elderly patients will find it difficult to access the medical care they need. While public officials wrangle about economics and cost cutting, physicians are far more concerned with the welfare of their patients.

Medicare Bulletins have a new look

*Edie K. Register, Director
Health Care Financing, Colorado Medical
Society*

Along with having a new Medicare Carrier for Colorado, Blue Cross Blue Shield of North Dakota, we also have Medicare bulletins with a new look. They are gray and burgundy and titled *Medicare B News*. Because of the high volume of mail you receive in your office, I did not want you to think the publication was from somebody trying to sell a subscription and tossing it.

That is what almost happened to me.



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an
associate with the law firm of Mont-
gomery Little & McGrew, PC.

*This column is not legal advice,
but is for general information only. For help with specific
problems, readers should consult an attorney.*

More Short Takes on Cases of Potential Interest

David M. v. Erie County Dept. of Human Serv.

The Ohio Court of Appeals held that hospitals and physicians have no common law duty (a duty created through case law as opposed to statutes) to diagnose and prevent child abuse. The duty with respect to child abuse instead arises solely from Ohio's child abuse statute, and involves the obligation to report suspected child abuse to proper public authorities. In the case before the Court, the hospital and physician, which did notify the appropriate authorities, fulfilled their duties to the patient, and were therefore entitled to judgment in their favor as a matter of law. *David M. v. Erie County Dep't of Human Serv.* (Ohio Ct. App. 1994).

Moskovitz v. Mt. Sinai Medical Center

An orthopedic surgeon in Ohio failed to timely diagnose and treat a malignant tumor, then altered certain records to conceal his medical errors. The jury awarded the patient, who died before trial, \$3 million in compensatory damages on the malpractice claim, and \$3 million in punitive damages, based upon the physician's alteration of the medical records. The appellate court upheld the award of punitive damages, even though the patient had not proven harm from the alteration of the records which was distinct from the harm caused by medical malpractice. The award, however, was lowered to \$1 million by the state supreme court. Practice tip: Punitive damage awards generally are not covered by professional liability insurance. Nor are they dischargeable in bankruptcy. In the absence of extraordinary circumstances (such as bad faith on the part of the insurance company for failure to settle the claim), the physician alone would be responsible for satisfying the \$1 million judgment. *Moskovitz v. Mt. Sinai Medical Center* (Ohio Sup. Ct. 1994).

Fisher v. Hanson

In a case involving genital warts and bankruptcy law, a Minnesota Bankruptcy Court held that a debt which resulted from the knowing and willful transmission of Human Papilloma Virus (HPV) was not a non-dischargeable debt under federal bankruptcy law. The debtor, who knew he was infected with HPV, entered into an unprotected sexual relationship with the "creditor". When she asked about a visible wart, the "debtor" said it was an old scar. He later admitted that he knew about but failed to warn her that he was infected with a communicable disease. Because the injury was found to have been willfully and maliciously inflicted, and was substantially certain to have occurred due to unprotected sex, the debt was not dischargeable in bankruptcy. A body of law involving the transmission of sexually transmitted diseases has evolved in the past few years. Knowledge on the part of either or both participants is key to the issue of liability. *Fisher v. Hanson* (Bankruptcy Ct. Minn. 1994).

Matt v. Burrell, Inc.

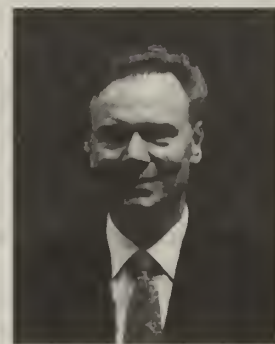
The Missouri Court of Appeals recently addressed a case which illustrates the dilemma encountered when determining whether a mental health institution has a duty to protect innocent people from mentally ill individuals known to pose a threat to themselves or others. "LeAnn" was a mentally ill, depressed and suicidal patient at a community psychiatric rehabilitation center. She told her therapists that she intended to leave the center and kill herself by wrecking her car. Her therapists permitted her to leave, even though they knew of her plan. "Mary" died when "LeAnn" drove her car head-on into Mary's car. The lawsuit filed by Mary's husband and children against the center was dismissed. The Court concluded that the center did not owe a duty to LeAnn, a member of the general public, arising from the decision to release LeAnn from the center, reasoning that LeAnn was a voluntary patient and "no such duty arises with respect to the release of voluntary patients". Food for thought: Why wasn't LeAnn placed on an involuntary hold given her plan? Moreover, is the status of the patient (voluntary vs. involuntary), or is the specificity of the target of the violence (individual vs. the general public), or is something else, a legitimate deciding factor in determining whether the institution owes a duty to the injured party? See *Matt v. Burrell, Inc.* (Missouri Ct. App. So. Dist., Div. 2, 1994).

Correction



Louise McDonald, MD

The article entitled *Corporate Practice of Medicine—No Longer “When?” but “How?”* (*Colorado Medicine* for December, 1994, Vol. 91, No. 12, p. 429) was written by CMS Board Member Louise McDonald, MD and CMS President-Elect Joel M. Karlin, MD. We regret that Dr. McDonald and Karlin were not given proper credit for their insightful analysis of the issues surrounding the corporate practice of medicine and the stance taken by the House of Delegates.



Joel M. Karlin, MD

Call for Nominations

The Nominating Committee will meet during the Interim Session in March to consider nominations for President-Elect, Speaker and Vice-Speaker of the House, two AMA Delegates and two AMA Alternate Delegates and any other offices of the Colorado Medical Society. All persons being considered for elective office must be cleared through this committee. This includes those who will stand for reelection. If you desire to run for office or to nominate someone, please contact Mary Lee Johnston at the Colorado Medical Society (303-779-5455 or 1-800-654-5653) or Dr. Barbara Reed, Chair, CMS Nominating Committee, 2200 E 18th Ave., Denver CO 80206, (303-322-7789). Make this contact as soon as possible so that the committee can properly prepare its report to the House of Delegates.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Advisory Council on Health Programs for Women and Children

Regular monthly meeting.

For information call Suzette Clark at (303) 692-2421.

Long Term Care Advisory Committee

January 10, 1994

4300 Cherry Creek Drive South, Denver

10am. -noon, Board Room, 5th floor

Contact: Louann Dicus at (303) 692-2837

Colorado Domestic Violence Coalition

Beyond Abuse and Addiction...Integrating Theory and Practice

January 12-13, 1995

University of Denver College of Law, Lowell Thomas Law Building

Contact: Gail Lorenz - (303) 972-4803

American College of Cardiology

Cardiovascular Conference at Snowmass

Snowmass, CO

January 16-20, 1995

21.5 Category 1 AMA

The American Diabetes Association and The Colorado Society for Endocrinology and Metabolism

32nd Annual Colorado Diabetes/Endocrine Institute presenting highly scientific Didactic Lectures and panel discussions on Diabetes and Endocrinology.

January 21-26, 1995

Aspen-Snowmass, CO.

Contact: (303) 778-7556

HealthONE

The Millett Symposium—The Liver Under Siege:

Chronic Active Hepatitis in the '90's

January 28, 1995

Presbyterian/St. Luke's Medical Center

Contact: Mary Fletcher, 303-869-2244

The Tenth Annual Rocky Mountain Regional Conference on HIV Disease

February 3-4, 1995

Red Lion Hotel, Denver, CO

For information contact: Terry Stewart (303) 837-0166 ext. 401 or Peter Ralin at (303) 436-7221.

American Management Association

OSHA and the Medical Industry: A Compliance Update

Feb. 21, 1995

Denver, CO. - Executive Tower Inn

Contact: 1-800-821-3919

American College of Cardiology

Second Annual Workshop on 2-D and Doppler Echocardiography at Vail.

February 27-March 2, 1995

Radisson Resort-Vail- Vail, Colorado

CME: 17.5 Category 1 AMA

Contact: (301) 897-2695

Medical Records Institute

"Toward an Electronic Patient Record '95: Eleventh International Symposium on the Creation of Electronic Health Record Systems and Global Conference on Patient Cards.

March 14-19th, Orlando, Florida

Contact: Leslie Campbell- (617) 964-3923

Presbyterian/St. Luke's Medical Center

New Developments in Cancer Biotherapy: the 2nd Decade

March 30-April 2, 1995

Beaver Run Resort, Breckenridge, Colorado

Contact: Mary Fletcher, 303-869-2244

HealthONE

Geriatric and Surgical Urogynecology

March 31-April 2, 1995

Beaver Run Resort, Breckenridge, Colorado

Contact: Mary Fletcher, 303-869-2244

Colorado Society of Osteopathic Medicine

Annual Meeting

June 16-18, 1995

Snowmass Conference Center, Snowmass at Aspen, Colorado

Contact: Patricia Ellis (303) 322-1752





*David C. Martz, MD
President, 1994-1995*

Fellow CMS Members:

We have just returned from the Annual Meeting of the American Medical Association, December 2-7, 1994 in Honolulu. It was a most beneficial experience in many areas — not the least of which was the opportunity for a change of pace from the hectic responsibilities created by being your President. A detailed review of the AMA meeting by our delegation will be forthcoming.

However, as *your* president, I give you the opportunity here to enjoy the show-stopping address of *our* president — Dr. Robert McAfee — caricaturing the recent behavior of *THE* President, Bill Clinton. I offer the entire text of his presentation in lieu of my own comments this month for your enlightenment and enjoyment.

David C. Martz, M.D.

King Will and the Foul Humours: A Fable for Reform

Ladies and gentlemen, over the course of the last two years, we've been asked to believe several fairy tales in the name of health system reform. So today, I'd ask your indulgence as I tell one last fairy tale.

I'd like to tell you the story of King Will and the Foul Humours.

Once upon a time, there were a King and Queen who lived in a big,

white castle, surrounded by a big, black fence, that was regularly patrolled by knights wearing dark visors.

Before King Will had become King, he lived in a forest, where he took from the rich and gave to the poor. This made him quite popular — especially with the poor — but he mistook his popularity for wisdom, and no sooner had he moved into the white castle than he began searching throughout the Kingdom for problems to solve.

He said to the Queen: "Queen (for he always addressed her in this manner) do you perceive any problems in the Kingdom that crier out for solutions?"

The Queen replied: "Are you kidding? The knighthood could use a little more diversity. The plague is making a comeback. And every time you take your exercise, you can't stay away from the butcher shop."

Now, the King ignored this last comment, but the problem of the plague seized his mind.

He knew that many of his subjects were unable to see the Wizards — those Doctors of Physic who ministered to the ill. And he knew that the tithe for having their humours checked was rising faster than the Consumer Price Index.

But the King also knew that the magic of the Wizards was unsurpassed. Citizens from neighboring kingdoms would travel many leagues just to see them. And the vast majority of his subjects were well contented with their system of care, and could see a Wizard almost whenever they wanted to.

The King mulled over his dilemma — he was famous for mulling and wonking — and finally, he came to a decision. So he said to the Queen: "It is up to us to give the people the health care they deserve".

Now a strange thing happened. The Queen might well have turned to the Wizards, who themselves had been discussing this problem and recommended remedies for many years. But instead, she summoned a noted sorcerer from a faraway land, Ira of the Unruly Hair. And Ira gathered a legion of fellow sorcerers, and convened them in a secret Star Chamber, a place so dank and dark no light could enter or escape.

They labored while the Spring blossoms scented the trees. And they labored while the sun ripened the fruit on those trees. And they labored while the leaves on those trees began to fall to the earth. Then, one day the Queen sent a crier throughout the Kingdom to announce that Ira of the Unruly Hair had indeed produced a mighty plan and it would be wondrous to behold.

Then they gathered every beast of burden in the Kingdom, all the oxen and horses and mules, and they hitched them to the machine on which they had placed the great plan — for the plan was not only great in inspiration but great in size — and they hauled it to the big, white castle and presented it to King Will.

And King Will, who was chewing on the drumstick of a great wonk, placed his seal upon the plan.

Now, on a hill looking down on the white castle was a great hal-
lowed hall with a round dome. And in that hall were knights of renown

from every other castle in the Kingdom. They were divided roughly into two camps, and the shields of one camp bore the sign of the donkey, while the shields of the other the sign of the elephant.

It was these knights' job to decide the laws of the land, but in truth, most of their days were spent in their favorite sport, which is jousting. The leader of the donkeys, Sir George of the Land of Lobster, was one of the most feared jousters. He said: "Let them bring us the plan of King Will, so we can make it the law of the land".

And the oxen and horses and mules began to haul the mighty plan from the white castle to the hall on the hill. But a hew and cry went up throughout the hall almost as great as during the debate over where the Knights could tie up their horses.

And the leader of the elephants, Sir Bobdole of the Land of Corn, who was famous for his skill with the lance, spoke: "Not so fast", said Sir Bobdole. "This plan has more fat than a roasted boar."

For it so happened that the donkeys and the elephants had opposing views on the health care of the people. The donkeys believed that the King and the knights should design the system, and decide what kind of training should be given to the Wizards and which Wizards the people could see. And the donkeys believed if the subjects would pay their tithe to them — they could fix the system.

But the elephants said the people were tithed too much and the money was wasted on things like midnight falconry. And they said the King and the great hall should stay out of it. And they accused the donkeys of being beholden to a knight of your, Sir Franklin of the New Deal.

So the knights of the donkeys and the knights of the elephants devised their own plans: Sir George of the Land of Lobster, Sir Chafee of Rhodes, Sir Stark of Fortney, Sir Teddy of Camelot and others. But the champion of one plan, Sir Rosty of the Windy City, was injured when he was out delivering a gift to a subject and fell into a moat.

But these plans, too — five in all — were also placed on great machines and hauled out to be viewed by the people. And the knights returned to their jousting.

And now thick fog hid the sun, and thunder rent the air, and torrents of rain turned the land into mud, and the plans of King Will and all the plans of the great Hall got bogged down.

All the while the Wizards offered advice and counsel on the health of the people. And the people heard them and gave the Wizards their confidence. But the King and Queen and many in the Great Hall gave the people only the cold shoulder and the deaf ear.

Now there arose in the land a new evil that further threatened the health care of the people.

One day, five great dragons from the Kingdom of Insurers appeared in the sky, and encamped in every corner of the Kingdom. And on their wide wings were markings sinister and strange. One had what looked like the giant rock of Gibraltar.

Another had what looked like a great umbrella of crimson. Still a third was marked with a small cartoon beagle.

People began to call them the Big Five, and they breathed fire, and made a bellowing that was terrible to hear, and were in general unmanly. And they began making forays across the land, swooping down upon unsuspecting subjects and herding them into their own regions.

They swallowed up entire villages. And they plucked up select Wizards, and demanded that they tend only to the citizens they had corralled, and none other. And the citizens raised up a cry because they could no longer see the Wizards who had so carefully watched over them.

But as the dragons' plunder continued, their appetites, rather than be sated, grew only more ravenous. It was rumored that some dragons even tried to eat some of the others. And clouds darkened the sky and a great indigestion struck the bowels of the people, and they were so afraid.

Ladies and gentlemen, most fairy tales end with everyone living happily ever after.

And for that to happen here, you might expect that a white knight would appear to slay the dragons and knock some sense into the King, the Queen and the knights of the hall on the hill.

But the ending to this story has yet to be written.

The great plans of the King and Queen and all the knights of the Hall got bogged down under their own weight. The wheels came off the machines, and all the King's horses and all the King's men . . . well, you're already familiar with that verse.

And as a result, many knights lost their shields and left the great hall forever — although most went on to join the newly-formed Guild of Lobbyists. Some who remained were hoping to fix the Kingdom's health system by mixing up a special magic potion. Its main ingredient was Eye of Newt.

Most of the knights, however, just went back to their jousting.

As for King Will and his Queen, the whole experience was enough to make them wish they were back in the forest, in their house surrounded by rushing white water.

The King has recently taken to traveling to foreign lands. But he never misses a chance to remind the Queen that you just can't trust a sorcerer.

What remains are the Wizards and the people — the true heart and soul of any health care system.

The people will continue to receive the best care on Earth when they demand nothing less.

We Wizards must never forget that we can deliver that care only if we're united in our vision, our voice and our leadership.

And I believe we can write a Fairy Tale ending if we never forget that the true power of our magic is now what's under our hats, but what's in our hearts.

And for allowing me the privilege to be your chief wizard for a year — I thank you very much.

Robert McAfee, M.D.

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society

Most of you are aware that I was born and raised in rural South Dakota. I lived on a ranch in the very northwest corner of the state. We were about 50 miles east of the Montana border and 20 miles south of the North Dakota border.

The landscape was made up of rolling hills, sage brush, wheat grass, and since we also had farming land, there were alfalfa, wheat, barley and oat fields. There was also a large (by South Dakota standards) hill which we called Flat Top just inside our west property line. I remember spending a lot of time looking for arrowheads and crocus on this hill. In the winter, I used the hill for sledding.

We raised cattle, sheep, quarter horses, and chickens, etc. In total we averaged 350 head of cattle, 1500 head of sheep, and about 25 horses. I never could and never wanted to keep track of the chickens. (Chickens are THE stupidest species on earth!)

Because we did farming in addition to ranching, I spent a lot of time on farming equipment. It seems we were either plowing, dragging, planting or harvesting. We also ground our own mixture of feed for the sheep and cattle. One of the most difficult chores was baling and stacking the hay.

I truly enjoyed taking care of the livestock. It was very difficult to handle these chores in the winter when the fierce South Dakota wind blew so cold and strong across the prairie. Because of these severe winters, we often had to feed the livestock and break the ice from the troughs, ponds and creeks. In the spring we dealt with lambing and

calving, followed by branding and other activities that repulse most city folks.

Why am I telling you all this? Well, being raised in this environment I think I understand the problems that can occur in the delivery of health care in rural communities. The nearest available medical care to our family was in a town 30 miles away. There was a very small hospital with two physicians on staff, no emergency transport system other than the local volunteer fire fighters who had no medical training.

People living in rural communities often do not seek medical care as quickly as they perhaps should. They are a proud and strong bunch. If a rancher hurts his foot, chances are a good x-ray will never be taken as he will never take his boots off!

I remember taking some bad spills off Flat Top when sledding. My brother would patch me up and send me on my way. I should probably have gone in for x-rays. I remember a time when a horse kicked me in the arm. My dad said I would be fine and that I should "get tough". Two days later I was taken to the hospital.

There were several other times when accidents happened involving farming equipment or the livestock. It was not uncommon to drive 30 miles to the physician's office or hospital through treacherous weather conditions. Think of what this is like when a woman goes into labor.

The two available physicians were family practice physicians who were called upon to handle chronic ailments as well as every type of

*"I never could and never wanted to keep track of the chickens. (Chickens are **THE** stupidest species on earth!)"*

(Continued on following page)

EXECUTIVE DIRECTOR'S UPDATE

(Continued)

emergency. They were on call 24 hours a day, 365 days a year. Their patients sometimes came from as far away as 75 miles. These "country doctors" seemed to always be there when we needed them. Now that they have long since retired, the community is still having difficulty getting and retaining physicians. Sound familiar?

This problem is a constant in Colorado, too. CMS has been criticized for not assisting in alleviating the problems rural Colorado has in the delivery of health care. I am excited to report that we are finally taking steps to help. CMS now has a task force to address these issues. Dr. Martz appointed the right person to head up this project, Jack Berry, MD, a Family Practice physician from Wray, Colorado. The task force had its first meeting on December 3rd. It will not only be identifying the problems; it will be developing solutions to these problems. CMS will be working on legislative proposals for the 1996 Legislative Session. Once the specifics are identified, we will pass them along to you.

Because we are located in the Denver metro area, Colorado Medical Society is sometimes accused of being a "metropolitan medical society". However, approximately 60% of our state is classified as rural; therefore, the Rural Health Care Task Force is a very worthwhile project for CMS. Don't think just because we label something "rural" that it doesn't impact what goes on in the metropolitan area. Everything that happens in rural Colorado has a serious effect on life in the big city, including virtually every doctor's practice. Ask anyone involved with the state legislature and you'll soon find out this is true. We must represent the interests of all our members regardless of where they reside.

I believe that this type of project is long overdue. Those of you who know Dr. Berry should feel confident that the job will be done and done well

Medical Students Honored

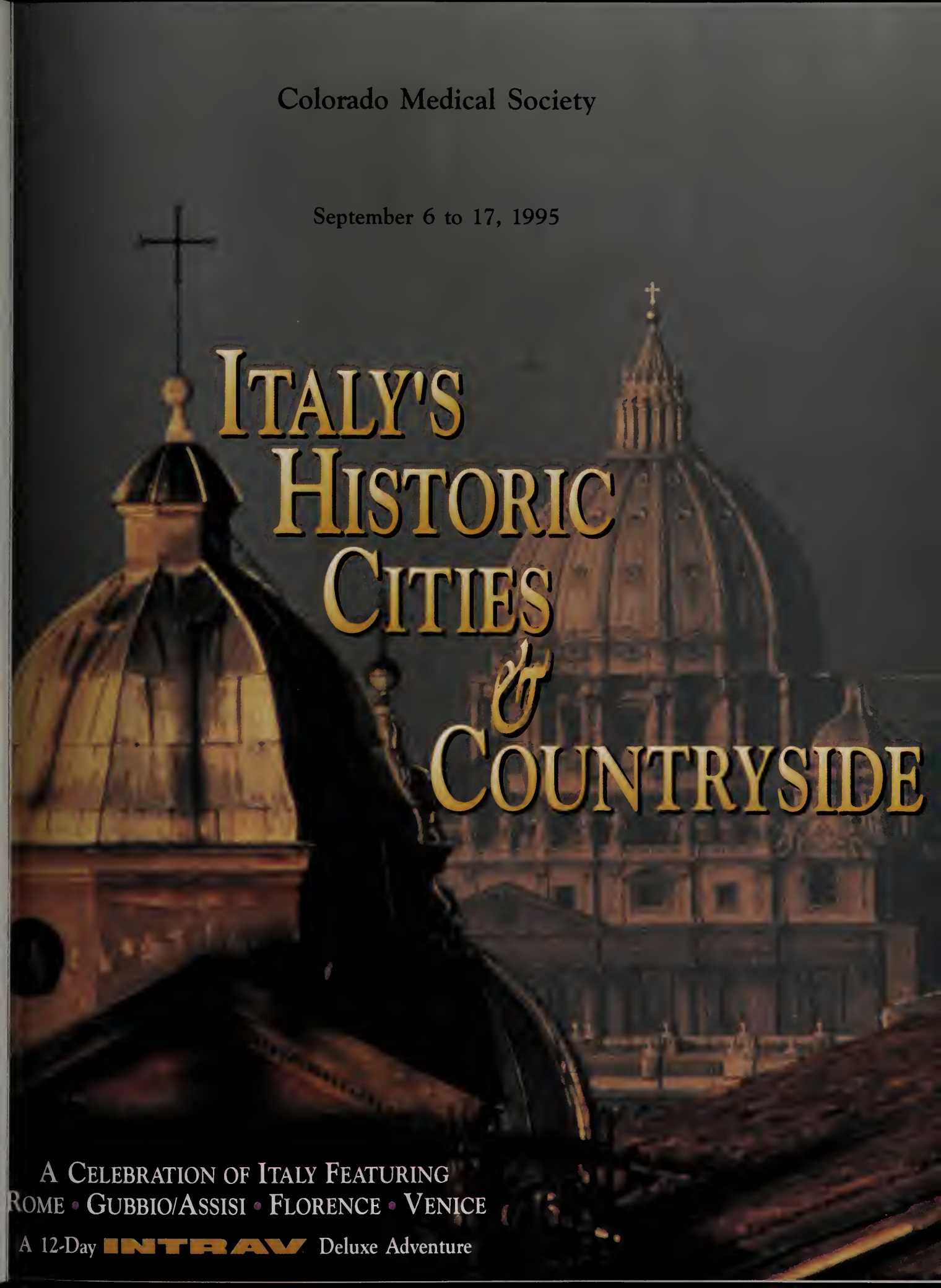


W. Gerald Rainer, MD, Chairman of the CMS Education and Research Foundation, presented a check to this year's scholarship winner, Trina Kessinger. The award presentations were made at the University of Colorado School of Medicine on December 9, 1994.

Dr. Rainer also presented the award for first place in the Medical Student Writing Contest to Peter Smith.



Second place honors in the Medical Student Writing Contest went to Jim Derrisaw.



Colorado Medical Society

September 6 to 17, 1995

ITALY'S HISTORIC CITIES & COUNTRYSIDE

A CELEBRATION OF ITALY FEATURING
ROME • GUBBIO/ASSISI • FLORENCE • VENICE

A 12-Day **INTRAV** Deluxe Adventure



EXPERIENCE THE FULL SPECTRUM OF ITALY

FROM HER CLASSIC CITIES TO HER RARELY VISITED

HILL TOWNS IN UMBRIA

AND TUSCANY

Italy is a land filled with tradition – a land that evokes a sense of history, passion and romance. Interwoven throughout is a tranquil beauty that captures the true essence of this sun-kissed nation, from eternal Rome to Florence, Italy's expressive "City of Art," to cosmopolitan Venice.

This intimate 12-day journey discovery promises a view of Italy that is no other. Embrace Italy's culture and tradition visits to her greatest cities. Then savor atmosphere of rural Italy as you quietly through winding back streets and drink in peaceful surroundings of quaint hillside towns and villages.

A solid foundation for this adventure is Rome, imperial and impressive. Visits to Vatican City and the Sistine Chapel offer a look at the masterpieces of Michelangelo. The Roman Forum, Colosseum, Trevi Fountain and other landmarks of Rome's past will all add historical perspective.

Hillside towns (left) and artistic masterpieces such as Michelangelo's David reflect the intimacy and beauty of a journey through Italy.



Step off the beaten track in Umbria and Tuscany, beginning with Spoleto and tranquil Gubbio. From there, visit Assisi with its renowned Basilica of St. Francis. The soft beauty of Italy's charming hill towns, Gubbio and Torgiano, and the intricate medieval architecture of Siena and San Gimignano add unique facets to this journey of exploration.

Renaissance treasures abound in Florence, where art, science and life find their most powerful expressions. Inspiration for both Leonardo da Vinci and Michelangelo, Florence is a vital city boasting a wealth of culture and history – Piazzale Michelangelo, Santa Croce Church, the Baptistery and, of course, Michelangelo's dazzling David.

Our unique perspective of Italy continues as we approach Venice by first-class train. A veritable whirlwind of sights and sounds, Venice is a luminously radiant city criss-crossed by canals. Here you can stroll along the Grand Canal, sip cappuccino in the Piazza San Marco, or experience an authentic Venetian gondola ride.



us for a scenic journey
Italy's most legendary
and quaint rural hillside towns.
AV's comprehensive and
the itinerary offers a beautiful,
icated and intimate opportunity
erience the true flavor and
here of a country whose art,
and architecture have
iced countless cultures
vide.

itials denote included meals:
kfast, L-Lunch, D-Dinner.)

— Depart gateway city.

LY

— Arrive in Rome, Italy,
the world over as the Eternal
for the next three nights, you
joy the comforts of the Regina
Baglioni. Located on fashionable Via
o Veneto, this classic hotel is
nient to many quaint boutiques and
lk cafes. The afternoon is at leisure
all through the inviting nooks and
es of the city or to simply enjoy a
ment at one of many outdoor cafes.



To enhance your
time at leisure, local
hosts at the
Hospitality Desk
are available to offer
activity suggestions
and dinner-reservation
assistance. This
evening, you are
invited to meet
fellow travelers at a
Welcome Reception
in the hotel.

Regina Hotel Baglioni

— This morning, explore Rome on
own or join an optional tour to many
city's highlights. Explore St. Peter's
e, Bernini's baroque architectural
piece completed in 1667 after 11 years
rk. Marvel at the immensity and
aking detail of St. Peter's Basilica.
g from the second century, the Castle
Angelo is another landmark worthy
visit. This afternoon, familiarize yourself
this impressive city on an included
ial Rome Tour. See the Roman Forum,
Colosseum, the Church of St. Peter in
s and the Trevi Fountain. (B)

icate facade of Siena's 14th-century Duomo rises
above the city.



Day 4 — This morning, you will
have the opportunity to join an
optional tour to the Vatican
Museums and Sistine Chapel.
Here you can delve into the
artistic treasures that encompass
more than 4½ miles of displays.
The masterworks of Michelangelo,
including the *Creation* and *Last
Judgment*, have been renewed with
10 years of careful cleaning and
restoration by Vatican experts to a
light that amazes the eye and
enriches the soul. The afternoon
and evening are at leisure to
spend as you please. Perhaps toss
a coin in the Trevi Fountain with
a wish to return soon to the
Eternal City of Rome. Once
again, your local hosts are
available to assist you. (B)

ITINERARY

Day	
1	Depart gateway city
2	Rome, Italy Welcome Reception Regina Hotel Baglioni
3	Imperial Rome Tour
4	Rome
5	Scenic drive to Gubbio with sightseeing in Spoleto en route Gubbio Walking Tour Park Hotel Cappuccini
6	Assisi and Torgiano Excursion, with lunch
7	Scenic drive to Florence with lunch and sightseeing in Siena and San Gimignano en route Hotel Berchielli
8	Florence Classical Tour
9	Florence
10	Scenic first-class train ride to Venice Venice Walking Tour Europa & Regina Hotel
11	Venice Farewell Wine and Cheese Party
12	Return to gateway city

Above left: A colorful guard
dutifully mans his post
outside the Vatican in Rome.

Above right: The gentle
spirit of St. Francis envelops
the quiet town of Assisi.

Rome/Spoleto/Gubbio

Day 5 — This morning, board a
comfortable motorcoach for a scenic drive
north through the scenic Umbrian
countryside to the ancient Roman town of
Spoleto. Renowned for its world-famous
festival of performing arts, *Festival of Two
Worlds*, Spoleto also offers much in the
areas of history and architecture. Its
Basilica of San Salvatore, dating from the
12th century, is among the most beautiful
in Italy. See the inspiring mosaic-work by
Salterno and view the series of frescoes in
the chancel created
by Filippo Lippi.

Other medieval
remnants include the
remains of a Roman
amphitheater, located
just off the bustling
Piazza della Liberta.
You will have time
for lunch and sight-
seeing on your own
before continuing
northward along the
quiet, winding roads to the walled medieval
town of Gubbio. Filled with narrow streets,
stone houses and tiny churches, this little
town transports you back in time to the
Middle Ages. This afternoon, enjoy a
walking tour of Gubbio. See the Gothic
Consuls Palace, which now houses a small
gallery and archaeological museum. Then
visit the Renaissance Palace of the Dukes of
Urbino. During your two-night stay in Gubbio,



enjoy first-class accommodations at the Park Hotel Cappuccini. Tonight, you are invited to a table d'hôte dinner at the hotel. **Park Hotel Cappuccini (B-D)**

Gubbio/Assisi/Torgiano

Day 6 — Today's included full-day excursion takes you through the lush hills and valleys of Umbria, the small, landlocked region set in the heart of the Italian peninsula. You will experience the special atmosphere of Umbria's quaint hill towns with visits to Assisi and Torgiano. First, stop in the delightful town of Assisi, still

alive with the gentle spirit of St. Francis. This morning, join an included walking tour of the 13-century Basilica of St. Francis, a fine example of Umbrian Gothic architecture. Actually two churches, one on top of the other, and both set over a huge monastery, the cathedral is a wonderful lesson in the history of art. You will break for lunch at the Poppy Inn, an old

peasant's house that has been transformed into an enchanting countryside restaurant. Next, stop in the wine town of Torgiano. Here you will enjoy a fascinating tour of the town's Wine Museum. Return to Gubbio for some free time and a table d'hôte dinner at the hotel. **(B-L-D)**

Gubbio/Siena/San Gimignano/Florence

Day 7 — On today's full-day drive to Florence, you will follow the country's secondary roads through the scenic region of Tuscany. Marked by a great diversity of landscape — undulating hillsides, open plains and regal mountains — Tuscany still evokes a sense of familiarity. Your first stop today will be in Siena, boasting the region's richest artistic heritage outside of Florence itself.



Above: Rome's Trevi Fountain is an artistic marvel of rushing water and marble sculpture.

Left: As you meander along village streets, experience old-world charm in its simplest form.

Below: Relax and unwind in the intimate atmosphere of Italy's quaint sidewalk cafes.

Right: See the historic towers that so dramatically symbolize San Gimignano's medieval past.

back to the Middle Ages. Lunch is included

Siena. Next, visit **San Gimignano**, a beautiful hill town ringed by three sets of historic walls. Boasting 14 of its original 72 medieval towers, the town is lovingly known as

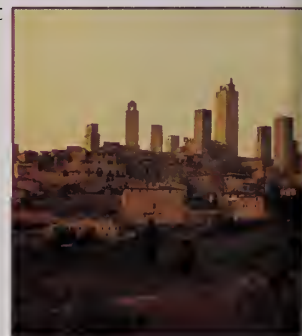
San Gimignano of the Beautiful Towers. The charming square of Piazza della Cisterna and Piazza del Duomo surrounded by medieval palazzi and towers, much in the area of architectural and artistic discovery. Arrive in Florence, Italy, in time for a relaxing evening at leisure. The next three nights, you will enjoy deluxe accommodation at the Hotel Berchielli, beautifully situated on the banks of the Arno River. Local hosts at the Hospitality Desk will be available to answer

questions, offer activity suggestions, and provide dinner-reservation assistance.

Hotel Berchielli

Florence

Day 8 — This morning, join fellow travelers on an included Florence Classical Tour. Visit several highlights of this Renaissance city, which shows artistic expression in fine detail. You will see the majestic Cathedral and the Baptistery with its famed bronze doors by Ghiberti. Also gaze upon Giotto's Campanile, the beautiful bell tower that stands just to the south of the Cathedral. Next, visit the Academy of Fine Arts Gallery on the eastern side of

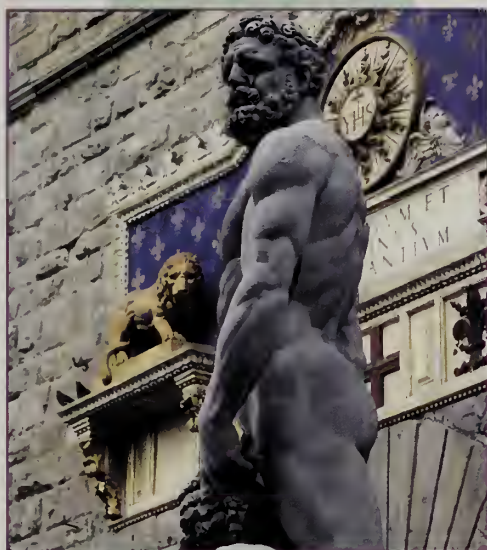


San Marco. Here is your chance to see Michelangelo's awe-inspiring *David*. Also stroll through Florence, a romantic city filled with cafes, sculptures and art. In the afternoon, explore on your own or join an optional Florence City tour to see more of the city's treasures, including Piazza della Signoria, Uffizi Gallery housing Florence's foremost art collection, Santa Croce Church and the hill town of Fiesole. The evening is yours to dine on your own and stroll through the city. (B)

— Today you have a free day in Florence to explore on your own. An optional full-day tour to Torre de Lago, Viareggio and Pisa is also available. The tour begins with a one-hour boat ride from Massaciuccoli to Torre de Lago to see the home of Italian composer Puccini. Then you will have free time in the delightful resort of Viareggio. Wander the charming streets and explore the town's secret treasures. Then continue on to Pisa, the charming city on the banks of the Arno River. The spacious lawn of the Campo dei Miracoli (Field of Miracles), you will see the Leaning Tower — all three exhibiting the Romanesque style of architecture. Then to Florence for a final free evening in this glorious city of art. Enjoy the atmosphere at an outdoor cafe, stroll along the avenues under a sky full of stars. Once again, local hosts are available for your convenience. (B)

Italy/Venice

Day 10 — This morning, board the express train for a delightful journey through the scenic countryside to Venice, a strikingly beautiful city noted for its vast network of winding canals. You will arrive in the early afternoon and transfer to the Europa & Regina



Above: Brilliant sculptures and other artistic masterpieces can be found throughout Florence, the expressive "City of Art."

Below: Venice's Basilica of St. Mark is one treasure among many on Piazza San Marco.

Right: A gondolier skillfully maneuvers his gondola along Venice's intricate system of canals.



Hotel. Located conveniently near Piazza San Marco and facing the Grand Canal, the hotel is a wonderful base for exploration of the city. Old-world charm and modern amenities will make your two-night stay in Venice a pleasant one. Afternoon sightseeing includes a walking tour of Venice to see many of the city's impressive landmarks. Piazza San Marco, historically the city's administrative and religious center, is certainly the heart of Venice. Always animated and filled with people, the square gives off an excitement reminiscent of the legendary carnivals, extravagant



processions and revelries held here even to this day. Nearby is St. Mark's Basilica, a Byzantine structure overflowing with lacy stonework, broad arches and a kaleidoscope of mosaics.

Also see the breathtaking Doge's Palace. As in Rome and Florence, local hosts at the Hospitality Desk will be available for your assistance. They can provide information about restaurants for your evening at leisure.

Europa & Regina Hotel

(B)

Day 11 — Enjoy a morning and afternoon at leisure. Perhaps you will want to join an optional gondola ride in the afternoon for a truly romantic experience. This evening, gather with newfound friends at a Farewell Italian Wine and Cheese Party. (B)

Day 12 — Flight returns to the gateway city. (B)

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NOTES: Final payment for all tours is due 70 days prior to the departure date. Credit cards cannot be accepted for final payment. All cancellations, for any reason whatsoever, will be subject to a \$100 per-person administrative fee. In addition, cancellations 60 days prior to departure are subject to an \$900 cancellation fee per tour participant, unless the accommodations can be resold. Domestic airfares are subject to applicable airline cancellation fees, are subject to change without notice and are not included in the cancellation fee above. All cancellations or claims for refund must be submitted in writing to INTRAV.

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Last (as it appears on your passport) Title First Initial

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Last (as it appears on your passport) Title First Initial

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☐ Enclosed is my deposit check, made payable to INTRAV.

☐ Charge my deposit to:

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Signature (as it appears on your card) _____

Please reserve round-trip flights to Newark from _____

(Departure City)

☐ Do not make flight reservations.

On international flights, I prefer:

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For Reservations Call 1-800-456-0020. Your Reservation Code Is: 07004-IHC-CMS95-09/06-

\$3399 per person, double occupancy, from Newark

Single supplement: \$750

At your request, INTRAV will make your round-trip domestic flight arrangements to Newark. Sample round-trip fare effective November 4, 1994:

Denver \$372

Airfares from other departure cities available upon request. Indicate the above, or other departure city, on the coupon. The fare will be reflected on your final invoice.

INTRAV provides complete pre-departure and destination information services.

Through a series of pre-departure mailings, we will provide sightseeing, climate and weather information, clothing and packing suggestions, and quick facts.

Toll-Free Number... we are only a phone call away. Passenger Service representatives will gladly assist with questions large and small.

Here's What Is Included

- Exclusive INTRAV group limited to 40 guests
- Round-trip scheduled flights from the gateway city to Rome and return from Venice, featuring the services of KLM Royal Dutch Airlines or Lufthansa German Airlines
- INTRAV Travel Director throughout the trip
- Exclusive Concierge service at the Hospitality Desks with local hosts in Rome, Gubbio, Florence and Venice

Rome

- Three nights at the Regina Hotel Baglioni
- Breakfast daily
- Welcome Reception
- Imperial Rome Tour
- Rome City and Vatican Museums/Sistine Chapel tours, specially priced options

Scenic drive with guided commentary from Rome to Gubbio, with sightseeing and free time in Spoleto en route.

Gubbio

- Two nights at the Park Hotel Cappuccini
- Breakfast daily
- Dinner each evening at the hotel
- Gubbio Walking Tour
- Assisi and Torgiano Tour, with lunch

Scenic drive with guided commentary from Gubbio to Florence, with lunch and sightseeing in Siena and a visit to San Gimignano en route.

Florence

- Three nights at the Hotel Berchielli, on the banks of the Arno River
- Breakfast daily
- Florence Classical Tour, featuring Michelangelo's *David*
- Florence City and Pisa/Viareggio tours, specially priced options

First-class train journey from Florence to Venice.

Venice

- Two nights at the Europa & Regina Hotel
- Breakfast daily

- Venice Walking Tour
- Gondola Ride, a specially priced option
- Farewell Wine and Cheese Party

Plus, Many Extras

- All airport/hotel/train transfers with the group in Italy, including tips to porters for luggage handling
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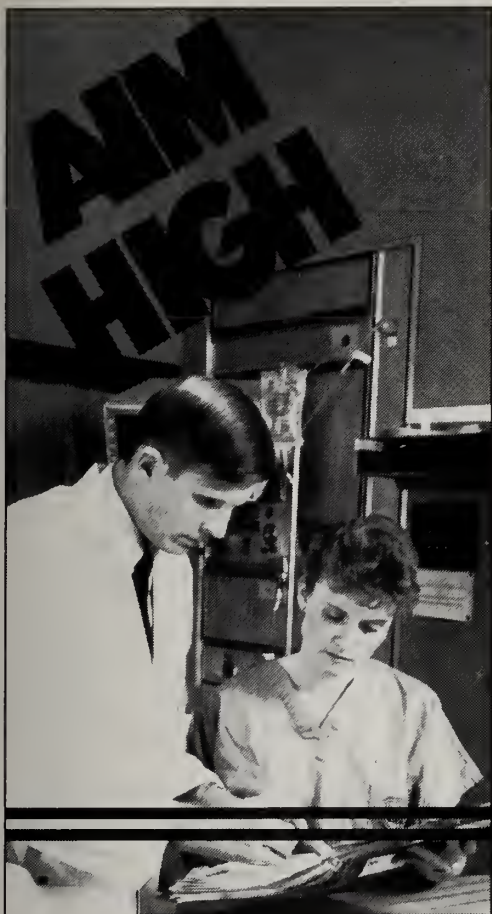
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LEGAL UPDATE

*from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
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Business Valuation: What is Your Business Worth?

Practices are valued for multiple purposes. In the typical divorce situation, the practitioner's business will be valued as part of the marital estate. In addition, a business is evaluated when it is sold, as part of the marital estate. In addition, a business is evaluated when it is sold, as part of financial planning, to create employee stock ownership plans, as part of buy-sell agreements among equity partners, and for estate and gift tax planning purposes.

Valuation methods include comparable sales, industry specialty methods, buy-sell agreements, multiples of gross revenues, discounted value of projected revenues, and capitalization of excess earnings, to name a few. Components of value include (1) assets and liabilities, including contingent assets and liabilities and good will, (2) balance sheet items, (3) accounts receivable, (4) cash flow, and (5) prepaid expenses and deferred liabilities.

In valuing good will, one looks at fees customarily charged, the location of one's practice, the strength of the referral base, the types of patients who generally utilize the professional, projected future compensation, competition, specialty, years of practice of the professional, reputation of the professional in the community, etc. Discounts may be utilized against good will if the sale is of a minority interest, the time which may be necessary to dispose of the interest to

be sold, recent sale of the ownership interest, first rights-of-refusal accorded to third parties, unfavorable recent financial results, the age and health of the principals within the organization, and the economic projections for the particular specialty or practice involved.

Practice valuations are particularly troublesome in divorce actions or partnership dissolution matters. The courts are not bound by the purchase price agreed upon by the principals in a professional practice. Rather, a court will hear valuations from certified public accountants and other experts who often provide widely disparate opinions of value, especially the value associated with good will. Well drawn buy-sell agreements which reflect reasonable and appropriate valuation methodology, coupled with mediation and binding arbitration provisions, often will save thousands of dollars in legal and accounting fees. However, partnership dissolutions and marital dissolutions are often bitter struggles which involve emotions of anger, jealousy, revenge, and rejection. Such human emotions mandate the intervention of legal and accounting professionals to maximize the potential of resolution of the valuation dispute.

For further information please contact A. Craig Fleishman, Managing Director.



THE LOBBY



Richard Allen, MD
Chairman, CMS Council on Legislation

"... there are nine societies, (including CMS) that have hired lobbyists already for the upcoming legislative session."

As your new Chairman of the Council on Legislation, the CMS staff has asked me to write a monthly column for **Colorado Medicine**.

A membership that is united in its legislative agenda is considerably more effective than a fragmented one. Toward this end, Colorado Medical Society President, David Martz, MD, and I have been working together since the early fall. There evidently has existed some divisiveness among our membership and a fragmentation which has made us all less effective than we could be. David addressed this in his November article, "A Vision For CMS." He went on to state "...this must be our

Year of Unification". A house divided cannot stand, especially against the external forces which currently threaten us.

We hope to develop and present a unified front against these forces, but before launching into a plan it is appropriate you know something about me and where I'm coming from. You're probably wondering, "Who is this guy, and where did he come from?" My most recent background and experience is briefly chronicled below.

Soon after his assuming the CMS Presidency, Dr. Martz approached me to help with the legislative goals of the Colorado Medical Society, and

Richard Allen, MD, Chairman, CMS Council on Legislation
Member: Denver Medical Society, Colorado Medical Society, American Medical Association, Colorado Society of Obstetrics & Gynecology
Specialty: Obstetrics & Gynecology
Medical Degree: New York Medical College, New York City, N.Y.
Internship/Residency: Emanuel Hospital, Portland, OR

Dr. Allen arrived in Denver in June, 1993, to serve as director of a residency training program at St. Joseph Hospital. He has been involved in medical education since entering practice in 1969, but only as a clinician, not a researcher. Dr. Allen says the training program offered a very appealing challenge and a refreshing change from the effects on clinical practice of managed care and health care reform.

During his practice experience in Oregon he served as President of his county medical society, the Oregon Medical Association and his specialty society. He also served as an Oregon Delegate to the AMA. In 1991 he was selected as "Oregon's Doctor-Citizen of the Year" and was deeply involved in Oregon's health care plan which became nationally controversial and which failed to gain federal approval. A proposal very similar to the proposed Oregon plan was attempted in Colorado in 1991.

Dr. Allen was well known in Oregon medical circles for his efforts to advance medical goals through legislative activities.

I am happy to offer whatever assistance I can. One learns from past experiences, and I did have lots of opportunities to learn. It is essential that all physicians work together to accomplish our goals. David Martz and I are on the same page, and you need to be too.

The present Council on Legislation has been carefully appointed to provide a broad range of representative viewpoints and backgrounds. There is no faction or "in-group" imposing its agenda on the membership at large. All views and opinions are welcome. The only agenda is what is good for all of medicine. While human nature is such (and physicians are no exception) that we may never have 100% concurrence, hopefully the overwhelming majority will all be together on legislative issues.

The Council on Legislation has now had two meetings (three, by the time you read this), and has looked at a number of issues in order to prioritize our efforts. Basically, there are issues that other non-medical (or at least non-MD) interest groups are planning to introduce to the Colorado Legislature. We must react to their proposed legislation, and be pro-active on issues we feel are important to us and that we feel have a need to create appropriate legislation. In addition to the normal channels and Medical Society committee structure and task forces, David and I felt that we needed to get together with any physician group which had a specialty-oriented legislative agenda, and maybe had even gone so far as to hire its own professional lobbyist. Consequently, on November 3, we invited the president and legislative chair of every specialty group to meet as a Congress of Physician Specialties (COPS). We defined as specialty any group recognized by the American Board of Medical Specialties and include the various primary care specialties including family practice as well as the surgical specialties. All of these are considered as "component societies of the House of Medicine". In spite of terrible weather that evening, there was an

excellent turnout and a valuable exchange of ideas. One of the things I was interested to learn was that there are nine societies, (including CMS) that have hired lobbyists already for the upcoming legislative session. On that basis alone, think of how much more effective we can be with the legislature if it were being lobbied by all of these groups on a unanimous front. One thing I've learned is that legislators get very confused when groups that they perceive are the same (like all doctors, regardless of specialty) lobby from conflicting positions. Thus, the more we are "together,"

the more powerful (and ultimately the more successful) we are.

In future issues of **Colorado Medicine**, I hope to discuss the legislative agenda items, where we stand, and most importantly what YOU can do. CMS and COMPAC have been busy trying to elect legislators who will listen to us and, as of the November 8 election, we feel we have been successful. Now we need to work together to express our needs and concerns to these legislators. Once again, your ideas are welcome. Contact the CMS Government Affairs staff or myself regarding issues that concern you.

Health Care Bills Probably In The Hopper

The Colorado State Legislative session begins on January 9th and the Council will meet on January 11- legislative proposals which we expect to be of major importance to CMS are listed below. There is no doubt that this list will have greatly increased by the time this issue of **Colorado Medicine** has reached your desk.

At the top of our priority list will be the bills which are submitted by the Legislative Sunrise/Sunset Committee on the continuation of practice acts for Chiropractors, Nurses, Medicine, and Podiatry. The Council will also be considering the following bills as possible high priority issues:

- Any Willing Provider Legislation for both health care providers and pharmacy.
- Cost Containment (HB 1186) *Data Commission Reauthorization
- Limitations on Prescription Drug Substitutions
- OB/Gyns as Primary Care Physicians
- Protection Bill for Limited Liability Partnerships
- Seat Restraints for Children Under 16
- State Equal Access to Pharmacy Discounts
- Trauma Systems

Other bills we expect to surface:

- A Proposal Addressing Counties Which Turn Their Backs on Mandates
- Child Support Program Tied to Licensure (All professional licenses, or possibly driver's or fishing licenses)
- EMS Training for Pre-Hospital Care - persons caring for children
- Tougher Penalties for Child Abuse
- Equitable Treatment for Mental Health Care
- Campaign Finance Reform
- Code of Ethics - Legislator's Conflict of Interest
- Consumer's Bill of Rights (
- Long Term Care Insurance
- Refinancing of School Districts for Medicaid
- Increase in Professional Licensing Fees to Support Disciplinary Actions for Professions With Few Members

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I.C. SYSTEM

Physician's Financial

Special Insert Number 1 for
Colorado Medicine, January, 1995

Bulletin

An exclusive member service of the Colorado Medical Society in collaboration with Chase Manhattan Investment Services, Inc.

Colorado Municipal Bond Update

by Chris Johns, Vice President and Portfolio Manager, Kirkpatrick Pettis
Investment Advisor to Tax-Free Fund of Colorado

1994 Review:

The supply of new issues of Colorado bonds can best be described as "feast or famine" for 1994. The famine occurred during the first nine months of the year as Colorado issuers waited for the Colorado Supreme Court to rule on the constitutionality of several bond elections that were passed in November, 1993. In October, the Supreme Court decided that voters do have the right to approve bond issues and tax increases required to pay them off. This resulted in the "feast" as over \$400 million in new bond sales came to market in about a 5 week span. The good news is that, although Amendment One or the "Taxpayer Bill of Rights" passed two years ago, the courts are finally starting to make interpretations and clarifications that give Colorado issuers some direction as to how they are affected by the Amendment. We expect that the new supply of bonds during 1995 will be more than evenly dispersed throughout the year, thus avoiding another "feast or famine" year.

A second major force driving the municipal bond market was rising interest rates. The yields on long-term municipals rose from about 5.75% a year ago to about 7.00% today. This rise in rates was caused by the Federal Reserve's inflation fighting efforts throughout the year. The Federal Open Market Committee acted six times during the year to raise short-term interest rates in order to slow down the

economy and curb future inflation rates. This situation of rising interest rates and falling bond prices was further exacerbated in the fourth quarter of 1994 as municipal investors took their first opportunity in seven years to use municipal bond sales as a tax loss vehicle. The widespread sales of bonds and redemptions of municipal bond mutual fund shares drove prices down even further. It is interesting to note that in late 1993 with yields at 10 year lows, municipal bond funds experienced record cash inflows. Now, a year later, with bond prices down about 10% and interest rates 1.25% higher, municipal bond funds are experiencing large redemptions. It would seem that this situation should create an obvious buying opportunity for the common sense investor.

Orange County, California report

The initial reaction of the municipal bond market was one of shock and immediate downward pressure on bond prices. In the past few days, some sense of normalcy has returned to the municipal bond market and only those California issues that are directly affected by the bankruptcy remain depressed in price.

In the state of Colorado, we operate under a much different set of guidelines than those that exist in California. House Bill 1056, which was passed in 1989, is designed to spell out the legal investments

(Continued on page 2)

Market Data

Indicator	12/31/93	12/8/94
Prime Rate	6.00	8.50
CD (180 day rate)	3.55	5.92
6 month T-bill	3.29	6.33
30 yr. T-bond	7.40	7.87
DJIA	3758.59	3685.73
S&P 500	435.710	445.45

Mortgages-New Purchases

No discount fee - No obligation fee

	Dec. 8, 1994	Dec. 8, 1993
30 year fixed	10.0%	7.00%
7 year fixed	9.375%	6.875%
5 year fixed	9.125%	6.62%

These rates are subject to change without notice.
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for public entities in Colorado. The primary focus of the Act was on safety and liquidity of publicly invested funds. These state regulations do not permit the use of derivatives or derivative-related securities.

Colorado also has several local government investment pools which are designed for local municipalities to use as a depository for their short-term investment needs. We have reviewed the most recent prospectuses, annual reports, security holdings and investment practices of these pools and have found that they comply with state regulations and do not make use of derivatives or other leveraged investment securities.

Kirkpatrick Pettis has always made it a policy to review the investment practices of our municipal holdings. We make every effort possible to discover any improprieties associated with the securities we hold and we are satisfied that all is in order with the information that is currently available to us. It may take years to sort out the complexities of the events in Orange County, but history tells us that after cathartic events like this occur, policies and procedures are rapidly put into place that prevent any such reoccurrence.

Denver International Airport (DIA) Bonds

What discussion of Colorado bonds would be complete without at least some mention of DIA bonds? 1994 proved to be a turbulent year for DIA bondholders. With a luggage-eating baggage system, several opening delays, allegations of faulty construction, substandard runways, questionable contracts and bond rating downgrades, 1994 has proven to be a very volatile year for owners of the \$4 billion debt securities. We believe that there is still a small risk of technical default for the bonds if further opening delays continue; however, it is our best guess that the Airport will open sometime in the first quarter of 1995. This will enable the facility to generate revenues to make current interest and principal payments on the bonds.

Due to the volatile nature of these bonds, I feel compelled to point out that the Tax-Free Fund of Colorado has avoided any investments in this project to date.

1995 Strategy

Despite all the wringing of hands and gnashing of teeth regarding the future course of interest rates, municipal bonds remain a very safe and attractive investment. Under current tax laws, a married Colorado investor in the 36% Federal tax bracket can purchase a 10 year, AAA rated Colorado bond at a 6% yield which is the equivalent of 10% for a fully taxable investment. Eventually, investors will rediscover the benefits of double tax exemption and Colorado bond prices will again rebound.

The key strategy for Colorado bond buyers will be security selection. By Constitution, the state of Colorado cannot issue general obligation debt. As a result, we have over 1,900 governmental units that can issue debt. Each issuer must be evaluated on its own merit as to how it is responding to changes in legislation, economic conditions in its own district and statewide demographic and economic circum-

stances. Some issuers are very sensitive to these developing situations while others are not. It will become increasingly important to monitor these municipalities as the economic fortunes of Colorado expand and contract over the next several years.

We at the **Tax-Free Fund of Colorado** have always pursued a very conservative investment philosophy. We believe that predicting the future direction of interest rates is an inexact science at best. Given that, we utilize an intermediate term maturity (10.5 years), high quality approach that reduces share price volatility regardless of the changes in interest rates.

We also emphasize extensive credit analysis on all securities which we hold. As a Denver-based investment advisor, we have contact with all the treasurers and financial officers of the municipalities with which we make investments. This allows us to anticipate nay problems or foresee opportunities which can be of benefit to our shareholders.

Summary

In summary, it appears that the Federal Reserve may act to raise interest rates again in early 1995. We believe that the worst of the bear market for bonds is behind us and that there will be a good supply of high quality Colorado bonds available for investment. A defensive investment posture with the proper amount of analysis should serve Colorado investors well over the next several years.

Enhancing Your Retirement Plan

by, Kathy Buys

Chase Manhattan Investment Services, Inc.

Are you fearful you'll outlive your money? With the government stipulating how much you can set aside in your retirement plan, will your current retirement assets afford you the opportunity to live as you currently are accustomed to? If these issues are of concern to you, you have probably been hearing about annuities. Annuities are not new.



Kathy Buys, V. P.

They've been around for along time. But today's general investment climate, along with reduced availability of tax-advantaged programs, have made annuities even more important. Technically, an annuity is a contract between a life insurance company and an individual and are sold by a variety of financial institutions. There are two types of annuities - *deferred* and *immediate*. Immediate annuities are generally used as income programs which provide an assured, systematic, tax-favored

method of distributing wealth. Payments from the immediate annuity can be structured over a specific period of time or over a lifetime. A portion of each payment is tax free, as it is a return of principal.

Because immediate annuities are specifically designed to distribute income, regardless of age, there is no IRS penalty on payments. The most popular type of annuity is deferred. Deferred annuities are designed to accumulate money while shielding it from current income taxes. Two types of deferred annuities are *fixed* and *variable*.

Fixed annuities offer:

- Safety of principal guaranteed by the issuing insurance company to preserve capital
- Competitive interest rates ranging from one to 10-year guarantees to outpace inflation
- Tax Advantages to defer taxes on earnings and build wealth more quickly and effectively than a taxable investment
- Easy access to your money as your investment goals and objectives change over time
- Guaranteed minimum interest rate by the issuing insurance company for a secure interest rate in all market environments
- No up-front sales charge so all your money goes to work for you immediately
- Security for your beneficiaries through a guaranteed death benefit by the issuing insurance company

Variable annuity offers:

- Professionally managed portfolios - similar to mutual funds - giving you the opportunity to maximize investment returns through portfolios comprising stock, bond and government securities. Because underlying investments fluctuate with market conditions, the principal is not guaranteed
- The ability to defer taxes on income and capital gains and to build wealth more quickly and effectively than a taxable investment
- Tax-free transfers among professionally managed portfolios
- Security to your beneficiaries through a minimum death benefit guaranteed by the issuing insurance company
- No up-front sales charges so all your money goes to work for you immediately
- A choice of broadly diversified portfolios to meet varying investment objectives
- The ability to transfer among portfolios - normally at no cost - as your investment goals change

Variable annuities may be invested for growth, income or a combination of the two. The flexibility of these programs makes them appropriate for tailoring income and growth components to your individual needs. And as your needs change over time, the mix of underlying growth and income investments may be

adjusted accordingly. Variable annuities also offer the opportunity of guaranteed income. At some future time, usually upon retirement, you can choose to annuitize the contract. By annuitizing the contract the issuing insurance company guarantees you monthly income for as long as you live.

Because they are tax deferred, the money you earn on your principal is not taxed until you begin collecting payments - which is usually years from now. The result of tax-deferred compounding is faster capital growth, unlike other investments whose current income is taxable (like bank certificates of deposit).

Although annuities make sense at practically any stage of life, they are perhaps best suited to middle-aged people in high tax brackets looking toward retirement in 10, 15, or 20 years. For example, you could purchase an annuity while still in a high tax bracket and elect to begin receiving your payments at retirement when you will be in a lower bracket. Annuity buyers should have enough liquid investments that they will not need to withdraw funds prematurely from the annuity. There is a tax penalty for early withdrawal, and most sellers of annuities charge a fee if you take back your money in the early years. An annuity is therefore an ideal supplement to your retirement income from Social Security, company pension plans and IRAs or Keoghs.

The professional money management, tax advantages and flexibility offered through variable annuities make them appropriate programs to help build a solid financial foundation. If you are serious about achieving your future goals, then there may be an annuity that is right for you.

Kathy, please contact me regarding (please circle topics):

Annuities

Zero-Coupon Bonds

Tax-Free Bonds

Free Portfolio Analysis

Retirement Plan Alternatives

Home Mortgages

Other:

Name _____

Address _____

Phone (H) _____ **(W)** _____

Best time to contact: _____

Watching Your Money Multiply With Zero-Coupon Bonds

by, Kathy Buys
Chase Manhattan Investment Services, Inc.

Q: What exactly is a zero-coupon bond?

A: Zero-coupon bonds have become a popular medium and long term investment but many people find them confusing. First because of their name (how can anything offering zero interest be a good investment?), and second, because of the sheer variety available. Adding to the confusion is the fact that many of them sport cute nicknames like CATS, RATS, STRIPS, etc., which are merely acronyms for the various zero products.

Zero-coupon bonds, of course, do earn interest. What they don't do is pay it out periodically over the life of the bond like conventional bonds. Instead, the interest continues to compound until the bond reaches maturity. Zeros are not for the investor who is looking for current income since the interest is not accessible.

Q: Are there different kinds of zeros?

A: There is a wide selection of zeros to choose from, each with different maturities and yields. You can work with your Financial Advisor to select the type of zero which matches your individual needs.

There are "**Government Zero-Coupons**," such as treasury zeros which offer a high degree of safety because they are backed by U.S. Government agencies which guarantee the timely payment of interest and principal at maturity. Maturities range from one to 30 years, with some issues exempt from state and local taxes. An-

other kind of zero is the "**Corporate Zero**" which offer the highest yields of all zeros. They are rated by independent bond rating services, ranging from the highest quality - AAA- to below investment grade - BBB. Choose a corporate zero that reflects your risk tolerance.

There is also the "**Tax-Free Municipal Zero**" coupon bond. These bonds could increase your after-tax return. Funds that normally would go to the tax collector can go instead to purchasing yield-generating investments.

Q: Are there any drawbacks?

A: Like conventional bonds, zeros are vulnerable to market forces, primarily changing interest rates. So, while you are assured of receiving full face value if you hold a zero to maturity, you can lose money if you sell it early. Keep in mind that interest rates and bond prices move in opposite directions. If interest rates increase, the value of your bond will decrease. On the other hand, as interest rates come down, the price of your bond will increase in value.

Q: What are the benefits of zero-coupon bonds?

A: For the long-term investor zero-coupon bonds provide two important benefits: a deeply discounted price and capital appreciation. The discounted price means you can buy a bond with a high face value for a small amount of cash. And automatic compounding means that, at recent interest rate levels, your money can double, or even triple in 15 years or less if you hold the bonds to maturity.

Because you receive the full face value of the bond at maturity, zeros are an ideal investment if you want a specified sum at a specified date. Many people buy zeros to finance their children's education or their own retirement.



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For comments or editorial contributions, call (303) 782-8000 or write to:

PF Bulletin

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CMS



CHASE



Attention Physicians—MDs and DOs

Have you been reading the newspaper headlines?

THE NEW YORK TIMES **NATIONAL** SUNDAY, JULY 17, 1994

Despite Awareness of Risks, More in U.S. Are Getting Fat

By MARIAN BURROS

American adults may be more aware of the need to exercise and count calories than they once were, but more of them than ever are overweight.

The number of overweight adults, which had remained stable at about a fourth of the adult population from 1960 through 1980, suddenly jumped to a third of all adults between 1980 and 1991, according to a recent study by the National Center for Health Statistics in the Centers for Disease Control and Prevention.

For purposes of the study, obesity was defined as being 20 percent or more above a person's desirable weight. That is about 25 pounds for an average 5-foot-4-inch woman and 30 pounds for an average 5-foot-10-inch man.

The increase in obesity rates continues despite a growing awareness that it has a negative effect on health and despite the continued growth of the diet industry, now estimated to have revenues of \$40 billion to \$50 billion a year.

For 45 years, only one national medical specialty society has been teaching physicians in all medical specialties how to treat obesity — **The American Society of Bariatric Physicians (ASBP)**. The ASBP teaches how to treat obese patients and *not* obese rats.

Come to Aspen, Colorado, March 30-April 1, for ASBP's Regional Obesity Course. Learn the clinical and business aspects of adding bariatric medicine as an adjunct to your existing medical specialty and how you can successfully treat obesity with very low calorie diets, safe and effective pharmaceutical agents, non-pharmaceutical natural agents, diet, behavior modification, exercise, group therapy, etc. Our program will include some of the leading obesity experts in the world as well as clinicians with many years of experience in the successful treatment of obesity.

Please send me more information as checked below:

- ☐ **Regional Obesity Course, March 30-April 1, 1995**, Grand Aspen Hotel, Aspen, Colorado
- ☐ **Membership information** (Physician members receive patient referrals)
- ☐ **Complimentary one-year subscription to the American Journal of Bariatric Medicine, The Bariatrician**

Please Print: Name _____ Degree _____
Address _____
City/State/Zip _____ Phone _____

Mail form to:

American Society of Bariatric Physicians
5600 S. Quebec St., Suite 109A, Englewood, CO 80111
Telephone (303) 779-4833 Fax (303) 779-4834

The American Society of Bariatric Physicians (ASBP) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The ASBP designates this Continuing Medical Education (Annual Symposium) as meeting the criteria for 15 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association. The program is eligible for AOA-CME credits under Category 2-D.



THE WALL STREET JOURNAL
WEDNESDAY, JULY 20, 1994

Fat Pharm

Respect for Diet Pills Rises as Studies Shed New Light on Obesity

FDA Considers Brain Drugs To Lift Mood and Ease Compulsion to Overeat

A Possible Role for Prozac

By MICHAEL W. MILLER

Staff Reporter of THE WALL STREET JOURNAL

Janet Dresen, 50 pounds overweight, tried Weight Watchers, The Diet Center, the Stillman Diet, the Atkins Diet, raw juice fasts, an "applied kinesiologist's" high-fat diet and nearly every other diet she ever heard of. Nothing worked. She would lose 20 or 30 pounds and gain them right back.

Colorado Medical Society

Tentative 1995 Interim Meeting Schedule

To be held at the CMS offices:

FRIDAY, MARCH 10, 1995

11:00 am - 1:00 pm

Finance Committee

1:00 pm - 5:00 pm

Board of Directors

To be held at the Holiday Inn Southeast (Parker Road @ I-225)

FRIDAY, MARCH 10, 1995

6:30 pm - 9:00 pm

Women in Medicine

SATURDAY, MARCH 11, 1995

6:30 am - 5:00 pm

Registration

7:00 am - 10:00 pm

Office open

7:00 am - 8:30 am

Reference Committee Members

7:00 am - 9:00 am

Nominating Committee Open Forum

8:30 am - 9:00 am

Credentials Committee

9:00 am - 9:00 am

House of Delegates - Opening Session

9:30 am - 11:45 am

General Membership Meeting

-

Keynote:

12:00 N - 1:30 pm

Luncheon

2:30 pm - 5:00 pm

Reference Committee on Board of Directors/Constitution, Bylaws and Credentials

4:30 pm - 6:00 pm

Reference Committee on Health Affairs

SUNDAY, MARCH 12, 1995

6:30 am - 11:00 am

Registration

7:00 am - 12:00 N

Office open

7:00 am - 8:30 am

Arapahoe caucus

7:00 am - 8:30 am

Aurora-Adams caucus

7:00 am - 8:30 am

Boulder caucus

7:00 am - 8:30 am

Clear Creek Valley caucus

7:00 am - 8:30 am

Denver caucus

7:00 am - 8:30 am

El Paso caucus

7:00 am - 8:30 am

Larimer/Weld caucus

7:00 am - 8:30 am

Pueblo/Western Slope caucus

8:00 am - 8:30 am

Credentials Committee

8:30 am - 12:00 N

House of Delegates - Closing Session

Call for Nominations

The Nominating Committee will meet during the Interim Session in March to consider nominations for President-Elect, Speaker and Vice-Speaker of the House, two AMA Delegates and two AMA Alternate Delegates and any other offices of the Colorado Medical Society. All persons being considered for elective office must be cleared through this committee. This includes those who will stand for reelection. If you desire to run for office or to nominate someone, please contact Mary Lee Johnston at the Colorado Medical Society (303-779-5455 or 1-800-654-5653) or Dr. Barbara Reed, Chair, CMS Nominating Committee, 2200 E 18th Ave., Denver CO 80206, (303-322-7789). Make this contact as soon as possible so that the committee can properly prepare its report to the House of Delegates.

**This portion goes
to CMS**

Interim Meeting Registration

1995 Interim Meeting of the Colorado Medical Society, March 11-12, 1995, Holiday Inn Southeast

Name (*Please type or print*) _____

Name of Spouse/Guest (if attending) _____

Component Society _____ Office Phone _____

RESERVATIONS FOR EVENTS AND MEETINGS

(*Reservation deadline is February 24, 1995.* Reservations accepted on a first-come, first-served basis)

Number of
Reservations

Amount
Enclosed

SATURDAY, MARCH 11, 1995

12 Noon-1:30 pm Luncheon _____

Complimentary _____

HOTEL RESERVATIONS

Please use the hotel reservation form below to make your reservations directly with the Holiday Inn Southeast. **The deadline for room reservations is February 26, 1995.** The preferred rate will be extended to CMS members on a space available basis after February 26.

MEETING REGISTRATION

Please submit a registration form by February 24, 1995, if you plan to attend this Interim Meeting. We're delighted to receive it by mail, fax, or phone. We can check you in more quickly and efficiently if you've preregistered, in addition to providing more accurate and therefore cost-saving guarantees for our food functions. Thanks!

MESSAGES

For your convenience, a message board will be provided at the CMS registration desk. The hotel's phone number is 303-695-1700. (You may want to leave this number with someone.) If you need to be contacted, ask the hotel operator to transfer the call to the CMS registration desk or CMS office.

WHAT TO DO

Complete this entire form and return it to Colorado Medical Society, by mail to: PO Box 17550, Denver, CO 80217-0550, by phone to: 303-779-5455 or 1-800-654-5653 or by FAX to: 303-771-8657.

**This portion goes
directly to the
hotel**

Hotel Reservation Form

Colorado Medical Society
Interim Meeting
March 11-12, 1995

Please Reserve _____ Rooms for _____ Persons(s)

Name _____

Firm _____

Address _____

City/State _____ Zip _____

Will arrive on _____

Day Date Time

Will depart on _____

Day Date Time

Credit Card _____

Name Number Exp. Date

Type Room—

Single 1 person \$64

Double 1 Bed 2 persons \$64

Double 2 beds 2 persons \$64

Suite \$95, 100, 110

Extra Charge per person _____

No. Persons Adults _____

Children _____

Check One

☐ 6 pm

☐ Guaranteed

Estimated time of Arrival at Hotel _____ Sharing with _____

Current lodging tax is 11.8%. Group cutoff date is 2/26/95. Reservations will be held until 6:00 pm Denver time, unless accompanied by a first night's deposit or guarantee of payment to a major credit card (please include expiration date). CHECK IN TIME IS 3:00 PM, CHECK OUT TIME IS 12:00 NOON.

Return form to:  **Holiday Inn**

Attn: Reservation Department
3200 S. Parker Rd.
Aurora CO 80014

Or Call: 800-962-7672

RAM

Recent Affiliations and Mergers (in Colorado)

*Prepared by the Colorado Medical Society Health Care Financing Department
Edie Register, Director
Marijo M. Parkin, Program Manager*

Key: DP = Denver Post; CMC = Colorado Managed Care Newsletter; RMN = Rocky Mountain News; DBJ = Denver Business Journal;
C/M = Colorado Medicine

Here, now, is a synopsis of Recent Affiliations (or acquisitions) and Mergers in Colorado. Some of them are being "rammed" through with such speed the number and monthly growth are astounding. (This report represents just three months of activity that has been made public. It's not known how many other deals have been cut but are still under wraps.)

- HealthFirst Physicians, P.C. is a new consortium of approximately 30 primary care physicians on the west side of Denver. (CMC 9/9/94)
- Four northeast Colorado hospitals (North Colorado Medical Center, Greeley; McKee Medical Center, Loveland; East Morgan County Hospital, Brush; and Sterling Regional Medical Center, Sterling) are now under the management of Lutheran Health Services of Fargo, ND who specializes in operating smaller rural hospitals. This is a major step toward building a broad new health care network for northeastern Colorado. (DP 10/19/94)
- The final merger of Southern Colorado Health Plan with Foundation Health of Sacramento, California received regulatory approval and was expected to take place by the middle of November, 1994. (CMC 9/26/94)
- A new network of community health centers has been organized for the purpose of seeking managed care contracts. The network covers the vast majority of the state. (CMC 9/26/94)
- North Colorado Medical Center and individual physicians in the Greeley area are forming a PHO called High Plains Healthcare Alliance. (CMC 10/7/94)
- A merger between Columbia HCA and Medical Centers of America has created a group of the following related organizations:
Hospitals:
Aurora Regional Medical Center (ARMC), North Suburban Medical Center (NSMC), Columbine Psychiatric Hospital
Affiliated Physician Groups: Front

Range Medical Group (NSMC), Metro Group Medicine (NSMC), Primary Care Physicians of Aurora (ARMC), Summit Physicians Organization (ARMC)

Managed Service Organizations (MSO):

Colorado Health Care Management

Surgical Centers:

Lakewood Surgical Center, Centrum Surgical Center, MidTown Surgical Center

Medical Groups:

Rocky Mountain Healthcare Centers, Plum Creek Medical Center

Others:

Ponderosa Medical Plaza, Compass Point Medical Plaza, Columbia HCA Home Health (CMC 10/7/94)

- PruCare (Prudential's HMO) is converting to a group model HMO, offering a group model alternative to Kaiser. The group component is the Denver Medical Group. PruCare plans to have a total of eight physician office sites in the Denver metro area. (CMC 10/24/94)
- University Park Clinic has joined HealthONE. (CMC 10/7/94)
- A new physician company is being developed by physicians of HealthONE. This new company will be owned by the physicians who are currently shareholders of Managed Patient Care (MPC), Focus Health Services (Focus), and Mountain Medical Affiliates (MMA); and members of Total Care Network (TCN), Benchmark Physicians (Benchmark), Quantum Medical Group. This physician company is considering partnering

(Continued on following page)

with HealthONE to form a management services company.

(CMC 9/26/94)

- HealthONE is expanding to the north and west parts of the metro area giving them a presence across the entire metro Denver area. They are developing large medical centers capable of treating various medical conditions that do not require overnight hospital stays. Provenant and HealthONE, two of the four largest players in the Colorado health care market, are collaborating for support services such as housekeeping, administrative functions, and management of medical supplies.

(DP 10/19/94)

- Lutheran Medical Center is developing a strategy for ambulatory care in cooperation with Rose Medical Center, St. Joseph Hospital and Rocky Mountain Adventist Healthcare. (The Adventist system includes: Porter/Littleton Hospitals, Denver Managed Care Components, Team Care (PPO), Porter/Littleton Medical Group (PHO), Colorado PsychCare, SouthCare (PHO), Avista Hospital, Avista Medical Associates, Platte Valley Medical Center, Platte Valley IPA, Conejos County Hospital, Huerfano County Medical Center, Kremmling Memorial Hospital, Sedgewick County Memorial Hospital)

(DP 10/19/94)

- Exclusive Healthcare (Mutual of Omaha's HMO) and The Healthcare Initiative (a plan jointly owned by Rose Medical Center, St. Joseph Hospital, and Lutheran Medical Center) have begun marketing their services together. Speculation suggests that down the road the hospitals and their affiliated physicians are likely to make equity investments in the HMO. (DP 11/3/94)
- Provenant Health Partners, Rocky Mountain Adventist Healthcare, and Rose Health Care System are considering investments in a new HMO being launched by Ethix Sloans Lake. Sloans Lake was recently purchased from Ethix by Massachusetts Mutual Life.

(DP 11/8/94)

push behind Sloans Lake's move is to offer businesses one-stop shopping for traditional insurance, a PPO or an HMO and thus give employees a range of choices. As of Jan. 1, Blair Tikker, now CEO of Porter Memorial and Littleton Hospitals will become CEO of Sloans Lake. Henry Cleveland, M.D., current CEO, will stay on as chairman of the Board and Gail Leavins will become chief operating officer. Sloans Lake currently has 350,000 members in its PPO plan and 750,000 members in its auto-accident personal injury protection plan. Sloans Lake's provider network encompasses 3,500 doctors throughout Colorado, 2,500 of them in the metro area. It is speculated that Massachusetts Mutual and Principal Mutual, Sloans Lake's new majority owners, may be seeking a local hospital or hospital group as an equity investor in the HMO plan.

(RMN 11/20/94)

- The Colorado Division of Insurance has approved the merger of three managed health plans into what will be the state's largest health plan. FHP of Colorado, TakeCare and Comprefcare will become FHP Health Care beginning Jan. 1, 1995. The company is the result of a chain of mergers. TakeCare acquired Comprefcare in 1993. FHP International Corp. acquired TakeCare in June. The three companies cover 325,000 Colorado residents. FHP International is the fifth largest managed care company in the country.

(C/M 12/94)

- Fitzsimons Army Medical Center has struck a major, multimillion-dollar agreement with University Hospital, its related physician group, Children's Hospital, and National Jewish Center for Immunology and Respiratory Medicine. The agreement goes into effect around the first of the year. The agreement calls for University Hospital and its partners to provide substantial price discounts for medical care delivered to active and retired military personnel and their families. In exchange, the Department of Defense medical center will refer patients to the

University Hospital-led consortium for specialty services and routine services it can't deliver at its own facilities. (DP 12/1/94)

- Rocky Mountain HMO is expanding into Pitkin County (which includes Aspen) and Garfield County (which includes Glenwood Springs). These counties had previously avoided HMO activity. Approximately 90% of the physicians in the new service area will be participating. (CMC 11/14/94)
- Longmont United Hospital has asked the Colorado Division of Insurance for permission to start a health maintenance organization, UniCare. (DBJ 11/94)

COLORADO MANAGED CARE (CMC) (A newsletter)

Managed care has been around for a long time; however, it has grown in prominence concomitant with its changing definition and increasing controversial nature. One person among the first to see the coming tempest was James Hertel, President of Healthcare Computer Corporation of America (HCCA), a Denver firm whose purpose was to build a health care service organization which could tend the growing, changing needs of health care through database strategies.

Early on, Jim Hertel recognized the advent of managed care growth and the fact that Colorado was the national breeding ground for the largest variety of HMOs, PPOs, MSOs, etc. He started tracking these changes. That was nearly ten years ago, and HCCA began producing an annual directory of managed care players. This directory has now spawned the monthly *Colorado Managed Care Newsletter* which tracks the continuing changes in the managed health care field and reports related news.



RETIREMENT

Social Security Overhauls Disability Process

Plans for a revised disability application process, when fully implemented, will represent the most sweeping procedural changes instituted in the Social Security Administration's 38 year history of processing disability cases, according to Social Security manager Tom Przytarski of the Denver office.

Przytarski said the plan, announced by Social Security Commissioner Shirley S. Chater recently, will replace a process characterized by "excessive delays, endless paper shuffling and bewildering procedures."

When fully implemented over the next five years, the plan will reduce the time it takes to process a claim from 155 days to no more than 60 days and the number of employees required to handle a disability claim from 26 to eight. If the claim is appealed, it will reduce the time it takes to process that administrative appeal from two years to about seven months and will reduce the number of people who would have handled the case from 45 to 14.

Other major changes in the new disability claims process include:

- Personalizing the process by assigning one employee who is knowledgeable about the case to be the principal contact.
- Allowing disability applicants to become more directly involved in the claims process by showing them ways they can help obtain medical evidence to support their case.
- Eliminating an interim appeal

step so that a person whose claim is denied can immediately file for a hearing.

A Disability Implementation Task Force has been established to begin the process of implementing the plan. "We are committed to moving as quickly as possible, but such fundamental changes cannot be made overnight," Przytarski said. "For instance, some aspects of the plan will require extensive research and testing before implementation. Other proposed changes will require legislative action and many changes will be implemented through the regulatory process to allow for public comment before implementation."

Although the two disability programs administered by the Social Security Administration — The Social Security Disability Insurance program and the Supplemental Security Income (SSI) program for low-income people — accounted for less than 20% of SSA's 45 million beneficiaries last year, the claims processes for these two programs required the use of more than half of Social Security's administrative budget of \$4.9 billion.

In addition, Social Security has reached a critical juncture: applications for disability benefits have reached all-time highs, the process has produced a level of service viewed by the American public as unacceptable, and additional administrative resources are unlikely in an era of federal spending limitations and competing spending priorities.

"Commissioner Chater decided that what we need are major changes in our procedures," Przytarski said.

Ten months ago, Chater put together a "disability reengineering team" comprised of some of Social Security's most experienced and knowledgeable disability experts, including representatives of SSA's field offices and the state agencies that make initial disability decisions for Social Security. Following the release of a preliminary report in March, they sought public comment and presented Commissioner Chater with a final report incorporating those comments in August.

Przytarski said a copy of a full report describing the new process and the extensive work SSA did to develop it can be obtained by calling 1-410-966-8255 or by writing to SSA, Disability Process Reengineering Project, PO Box 17052, Baltimore, MD 21235.

1994 Informatics Fair

A Success

Looking forward to next year

by Mitchell Gershten, MD, Denver, Colorado

Computers are changing the practice of medicine. What once were ideas and dreams are now fast becoming reality and will soon become standard of care. Technologies that started first as a fancy way to monitor billing and practice management are rapidly spreading into readily accessible diagnostic tools, therapeutic decision making, medical education and training, patient file management and office/hospital networking. Computing power that initially rested in the realm of the technologically inclined is now being made available to everyone in user friendly, easily understandable modalities destined to impact the way in which medicine is practiced by all of us. The pace of this change has taken all but the most adept a bit by surprise and in fact has left many all but completely intimidated, a situation that no longer need apply. Indeed, much effort is being expended to make these powerful technologies readily

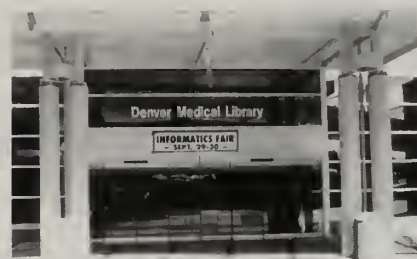
understandable and easily approachable for even the most severe technophobe.

Many of these technologies were highlighted at this year's 'Medical Informatics Fair' which took place at the Denver Medical Library. Our second year at sponsoring this event was an unqualified success and built on a tradition established previously of providing attendees with a glimpse of the latest technology and software being developed for the health care industry in a friendly and relaxed environment. The event was very well attended with physicians and allied health care professionals coming from all over the State of Colorado. Without exception visitors to the fair were clear in their need to

become familiar with these new and ever changing technologies as it was clear that they are rapidly becoming the standard of care and will directly impact the way all of us practice medicine in the future.

Attention is now being given to the Informatics Fair 1995 which will take place September 28 and 29. Focus will be given to medical education, practice management

software, virtual reality technologies in medicine and to the Grail of medical informatics: physician/hospital/clinic/payor Networking. The technology now exists to provide on-line transfer of data, such as history and physical reports, multi-specialty consultations and operative reports, biopsy reports, insurance information as well as actual images of x-rays and real time echocardiograms, catheterization images and other imaging modalities. The problems develop in the realm of vendor hardware compatibility, the enormous setup costs, decisions regarding basing of terminals and access, security and patient confidentiality. Once these issues are decided and the systems are decided and the systems are in place, the potential for streamlining the flow of information, reducing duplication of services, decreasing costs, and ultimately serving the patient population better will be quickly realized. We look forward to a successful Informatics Fair 1995.



Photos by Gil Maestas, II



C Comprehensive School Health:

A Chance For CMS to Make a Difference

By Mark Johnson, M.D., Chair, CMS Youth Task Force

At this year's Annual Meeting, the Colorado Medical Society's Youth Task Force was charged to "pursue projects on comprehensive K-12 health education in the schools that would allow CMS-wide involvement in its various facets, including community program planning, educational consultation, advocacy, promotion and provision of education." (RES-53-A, AM '94) In taking this action, CMS reaffirmed its support of comprehensive health education programs in all public schools (RES-34-P, AM '86) and joined the Colorado Legislature, the Colorado Department of Education, the Colorado GYN/OB Society, the

Colorado Department of Public Health and Environment, the Advisory Council on Adolescent Health, the Centers for Disease Control and Prevention, the National Association of State Boards of Education and the American Medical Association in recommend such activity.

In selecting comprehensive health education as its project for this year, the Youth Task Force took the following issues into consideration: this is an area that is vitally important; it is of interest to all physicians, regardless of specialty; Alliance members can take an active role in it; it has statewide impact, but is best dealt with at the local level with each community defining its own unique needs and desires, and; activities can be planned to correspond with the time and expertise available from CMS and Alliance members. In addition, we plan on joining forces with other organizations and agencies in the state, to pool the resources we have. While CMS has experienced medical personnel, we have limited funds; whereas other organizations may have funds, but need the knowledge and credibility that we can provide.

Many physicians have been active in schools by providing classroom lectures on health, or during career days. However, these isolated exposures can sometimes be more frustrating than rewarding. While health lectures may be a welcome change for the kids and provide the teacher with some momentary relief, they are seldom effective in producing long-term health behavior change.

Likewise, implementing pro-

grams and curriculum changes as a response to crisis situations, such as classes on drug abuse, teen pregnancy, HIV/AIDS, or smoking, have limited benefit. Experience shows that "comprehensive programs that include health services, health education, a healthy environment, and a supportive school health policy have been proven to be effective in altering both the knowledge and behaviors of students with respect to health issues and risk-taking behavior."¹ Such a comprehensive approach allows the incorporation of any curriculum or supporting programs that may address new health risks, while continuously promoting lifelong healthy behaviors.

In light of this, the Youth Task Force has been working closely with the Colorado Department of Education, the Colorado Department of Public Health and Environment and the Rocky Mountain Center for Health Promotion and Education on the development of this project. The accompanying list of activities shows the scope of possible involvement. To give us an indication of interest and to find out who may already be working in school health, we would appreciate it if you would fill this in and return it to CMS. We have also discussed putting together a short presentation for the component societies, and will be working with CMS leadership to further promote this project. We welcome your suggestions, and look forward to working with each of you on this most significant endeavor.

¹. *National School Boards Association Issue Brief No. 19.*

Ways for Physicians/Alliance Members to be Involved with Comprehensive Health Education in the Schools

Please check those activities in which you would like to become involved as well as those that you have done in the past, or are doing presently, and return this insert to CMS. The information will help CMS begin building a database as well as enable CMS staff to advise you regarding specific opportunities in your community.

Name: _____

Specialty: _____

Address: _____

Phone: _____ Component Society: _____

Activity	Time Commitment			Activities of Interest	Did in past	Doing now
	Low	Med	High			
Observe Health Ed. Classes at local schools	X					
Offer to be a classroom presenter for a health ed class	X					
Participate in schoolwide health promotion activities (e.g. judge poster or essay contest, participate in health fair, provide advice for staff wellness program)	X					
Write letters to the editor	X					
Mentoring or periodic student observations in your office	X	X				
Be a spokesperson for school health education in the community or at school board meetings	X	X				
Work with business and civic leaders in your community to serve as third party advocates for school health programs	X	X				
Serve on a school health education committee	X	X				
Serve on PTAs	X	X				
Serve on a committee to determine medical accuracy of health education curricula		X				
Serve on the Board of Directors for agencies with a mission related to school health programs		X				
Actively participate in the legislative process when school health issues are at stake		X	X			
Run for School Board			X			

If you have questions or desire further information, please call Lynn Livingston at the Colorado Medical Society 303-779-5455 or 1-800-654-5653

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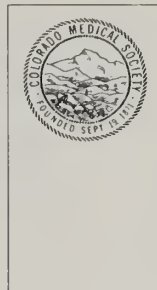
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Patti Brown, President
CMS Alliance

You are cordially invited to attend the
Colorado Medical Society Alliance
"Day at the Capitol"
Monday, February 6, 1995

8:30 am ----- Continental Breakfast at the Governor's Mansion, 400 East 8th Avenue. The cost is \$4.50 per person.

9:30 am ----- Guest speaker. Speaker will be announced at a later date.

10:30 am ----- Tour of the State Capitol. Meet at the North Entrance. The tour will take 30 to 45 minutes.

11:30 am ----- Meet your county legislators for conversation followed by lunch at the Radisson Hotel, 1550 Court Place, Denver.

Noon ----- Lunch will be served. The cost is \$16 per person. Each county is responsible for inviting their legislators, as well as the cost of their lunches.

1:30 pm ----- Capitol: Here's your chance to stay and sit in on the various committee hearings scheduled for the afternoon.

I wish to attend "Day at the Capitol" scheduled for Monday, February 6, 1995.

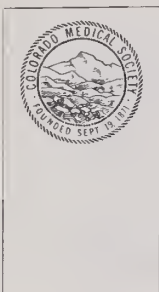
Number

_____ Breakfast @ \$4= _____

_____ Lunch @ \$16= _____

Total _____

Your check made payable to CMSA in the appropriate amount is your reservation. Send to Rosalie Schreiber, 1520 E. Maplewood Ct., Littleton, CO 80121 by January 31, 1995.



SCAM OF THE MONTH

Preventing Prescription Drug Diversion and Abuse

In 1982, Colorado ranked among the top 15 states in per capita consumption of 9 abused prescription drugs.

The American Medical Association claims it is the "hidden" drug abuse problem in our nation. According to data collected by Congress, the National Institute on Drug Abuse, and the Drug Enforcement Administration, prescription drug abuse is the cause of more injuries and deaths than all illegal drugs combined.

In cooperation with the Colorado Prescription Drug Abuse Task Force, *Colorado Medicine* presents various Drug Diversion Scenarios "scams" and offers possible solutions.

Colorado Prescription Drug Abuse Task Force— Board of Directors 1994- 95

President:

Irene Aguilar, M.D.
Denver Health & Hospitals/NHC

Vice President:

Michael Mapes
U.S. Drug Enforcement Administration

Tom Beckett

COPIC Insurance Agency

Bruce Douglas

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Denver Health & Hospitals

K. Suzanne Hamilton

Colorado Medical Society

Jo Ann Pegues

Administration on Aging

SCAM # 1. AGGRAVATED

STUMP SCAM- An expensive van, transporting a driver and four elderly passengers (each of whom has a missing leg) pulls into town. The van stops at the first available outside telephone. The youthful driver begins to randomly contact local doctors, requesting appointments for his passengers. Moved by the urgency of the medical condition described ("**My grandmother's from out of town and she has an artificial leg. Her stump is very sore. I think it might be infected. She's really in pain.**"), most of the doctors contacted agree to an immediate appointment.

As each wheelchair bound amputee arrives at the doctor's office, the driver makes individual inspections. If the stump being checked does not appear sufficiently aggravated, sandpaper is used to produce the desired effect. A convincing, well-practiced story is told to explain why the patient cannot use any pain medication but Dilaudid. The sympathetic physician usually issues the requested prescription, normally for a large quantity ("**Grandmother won't be able to see her regular doctor for at least two weeks.**").

After the Dilaudid prescriptions are filled (one per pharmacy), the

drugs are immediately sold to local drug dealers and the con artists are on their way to another town. The street price for a single 4mg. Dilaudid tablet ranges from \$55-60. Daily profits from such an operation can run as high as \$5,000.

SCAM # 2. PARAPLEGIC SCAM-

Physicians and pharmacists should be alert to the use of paraplegic patients in a drug scam. The Missouri Bureau of Narcotics and Dangerous Drugs has reported cases of such impaired persons scheduling multiple physician appointments on regular schedules throughout the state.

At least four such individuals are known to have become paraplegic due to gun battles with other drug dealers or with law enforcement officials. It is also known that some of these individuals do not suffer pain requiring Dilaudid, but simply use their condition to solicit sympathy, and thus secure prescriptions, from unwary health care professionals.

***See Solutions on
following page...***

SOLUTIONS FOR SCAMS # 1 AND 2

1. Utilize "Physicians Guidelines of Professional Practice for Administration of Controlled Substances".
2. Take the time to do a thorough medical history on *all* new patients.
3. Contact a prior physician whenever possible.
4. *Always* be suspicious of "urgency" in any request for medication, and examine the circumstances carefully.
5. Write prescriptions for the smallest amount of medication necessary for treatment.
6. Be alert to patients who seem overly familiar with, or who demand, specific medication.
7. Review office procedures with the office staff to avoid acquiring a reputation as an "easy mark" for con artists.
8. Request positive identification on all new patients (there is nothing improper about requesting a photo I.D. to confirm the patient's identity); record this information on the patient's medical history.
9. Make efforts to work closely with pharmacists in selecting the proper drugs of treating chronic and subjective pain; this also makes it more difficult to be fraudulently deceived by increasing personal knowledge of appropriate medications and developing communications with the pharmacists.

Directory of Resources for Maternal Substance Abuse and Children with Fetal Alcohol Syndrome or Perinatal Drug Exposure Available

In recent years, there has been an increasing awareness of the problems of maternal substance abuse and the consequent effects of alcohol and other perinatal drug exposures on children. In Colorado there are many programs that address some aspect of these problems. However, it is difficult to keep track of all the resources that are available. In response to this need for information about current services, the Colorado Department of Public Health and Environment, through the Colorado Registry for children with Special Needs and the Alcohol and Drug Abuse Division, has developed a resource directory. The directory is primarily for health and human services

providers. It contains descriptive information about available programs, as well as eligibility criteria, instructions for accessing services, service days and hours, and fees. The types of resources covered include child development programs, maternal substance abuse treatment programs, health services, family resources (child care, parenting, domestic abuse), legal services, prevention programs, coalitions, advocacy groups, and state and national resources. If you would like a free copy of this directory, please call April Montgomery at (303)692-2620.

Reprinted from the October, 1994 *Colorado Disease Bulletin*, Volume XXII, Issue No. 11.



DONALD J. NORTHEY, M.A.

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Warning flags fly: OIG and IRS collaborate in pursuit of health care prosecutions

by Bill Pierson,
Managing Editor

Denver attorney notes instances of federal repercussion in physician-hospital collaboration cases.

Analysis takes on new importance with increase in hospital-physician agreements.

In the wake of the many affiliations, buyouts, mergers and acquisitions occurring between medical practices, hospitals, managed care organizations, insurance companies, etc., special note must be taken of the legal risks attendant to these business plans.

Attorney **Donald J. O'Connor** of Davis, Graham and Stubbs in Denver authored a special analysis for CMS, alerting physicians to this newly enhanced danger residing in hospital-physician joint ventures. Mr. O'Connor provides vital information on:

- **How the Office of the Inspector General prosecutes "kickbacks"**
- **When IRS denies charitable exemptions for hospitals**
- **How these two agencies have entered an era of unprecedented cooperation**
- **Many activities once considered benevolent are now labeled "fraudulent" and "illegal".**

Mr. O'Connor has written an analysis for Colorado Medical Society that is easy reading. The analysis is based on an article O'Connor wrote for the *Colorado Lawyer*. This article gives detail and specific examples of interpretations of the law and how to avoid violations.

For instance, not all "safe harbors" are safe, and if you don't measure up to the rigid standards of participation, you're liable to find yourself outside the area of amnesty and with no proper defenses. As Mr. O'Connor describes, "If its requirements are met, the Investment Interest Safe Harbor will protect joint

venture participants from prosecution. However, the entrance to that Safe Harbor is very narrow and strewn with rocky shoals. Consequently, few if any, joint venture participants will find shelter from prosecution!"

Another example of what is happening as a result of the new breed of HPOs, MSOs and other such conglomerations, physicians are finding that the "**Medicare Anti-Kickback Statute**" is being used in "certain prohibited conduct". Such conduct is described as an offer to pay or payment, or the solicitation or receipt, of any remuneration to induce referral, or in return for referral of business reimbursed by the Medicare or Medicaid programs.

NOTICE

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First Liver Transplant at Porter

Surgeons performed Porter Memorial Hospital's first liver transplant procedure on December 7, 1994. The patient, a 58-year-old Denver woman, suffered from autoimmune hepatitis which resulted in cirrhosis of her liver. She had been on the national waiting list since August. The patient is recovering well.

Dr. Eric O. Kortz, medical director of the liver transplant program and CMS member, performed the surgery. Dr. Kortz came to Denver in 1992 from his training in liver transplantation at the University of Chicago.

The Liver transplantation program at Porter was approved by United Network for Organ Sharing in November 1992, making it the second hospital in Denver to offer liver transplants.

Liver transplantation is now the accepted method of treating liver failure, with 1-year graft survival figures above 80 percent for most patients.

Business side of medicine

Physicians as managers

We have touched upon the subject of physician career change more often recently (*Colorado Medicine* Vol. 91, No. 4: Med Fax and No. 5:190), as the motivations which drive physicians into other avenues of making a living increase in intensity. Now a new book from the

American College of Physician Executives analyzes the problems involved when physician take on careers as managers.

Author Robert M. Peters, MD, MBA makes a scholarly review of the literature and experience regarding physician performance as manager and gives some concrete help in avoiding the pitfalls. Dr. Peters notes that physicians often fail to identify with their roles as managers and continue to see themselves as having a career in medicine. Because of their training and focus as physicians, they can demonstrate apparent ego and arrogance attitudes and poor communications skills in management situations. Then can also lack the business training necessary for good management.

Dr. Peters goes into detail on these and other subjects with references, charts, footnotes and all the marks of a scholarly work. This is not light reading. The only other readily apparent drawback of this book is that it takes such a negative view, focusing on the problems and pitfalls of physicians as managers. However, if physicians can deal with those in an honest manner, it may help to avoid them.

The book is called *When Physicians Fail as Managers: An Exploratory Analysis of Career Change Problems*, by Robert M. Peters, MD, MBA, published 1994 by the American College of Physician Executives, 813-287-2000. Dr. Peters is a principal with an internal medicine and cardiology group practice in New Hyde Park, NY. He is a Senior Attending Physician at North Short University Hospital,

Manhasset, New York and also at Long Island Jewish Hospital in New Hyde Park. He services on the ACPE Society on Hospitals, Society on Managed Health Care Organizations, and Forum on Quality Health Care.

Private Practice as Business

With the increasing incursions of managed care, you must be more efficient in order to remain in the business of private practice. Yvonne Mart Fox, a practice management consultant in Beverly Hills has put into a 380 page step-by-step paperback book her insights from sixteen years of lecturing, consulting and writing for major medical publications in order to help the physician cope with the business side of practicing medicine.

How to Manage the Business Called Private Practice contains sections on time and staff management, personnel, managing the financial side of the business, confidentiality, managed care, practice promotion and basic decisions such as phone systems, office labs and even whether to hire your spouse as office manager. The book is \$39.95 (including shipping and handling). Call 213-934-9949 for more information.



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01/0195

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03/1294

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02/94

BOULDER - Urgent/Family/Occupational Medicine - Successful Medical Center seeking two BE/BC physicians for excellent opportunity in prime SE Boulder area. Minimal call. Flexible scheduling. Send C.V. and call Dr. Turnbow, Meadows Medical Center, P.C., 4800 Baseline, D-106, Boulder, CO. 80303. (303) 499-4800.03/1294

NATIONWIDE - Opportunities for the following: IM, DP, OB/GYN, PED, ONC, CD, and more. Send CV to Stan Kent, Stan Kent & Associates, PO Box 904, Tremont IL 61658 or call 800-831-5679, FAX (309) 952-5842.

22/594

EMERGENT/URGENT CARE PHYSICIAN Full and part time position in Lafayette. Flexible scheduling. Send CV or Contact Dr. Coryell, Community Medical Center, 2000 W. S. Boulder Rd., Lafayette, CO 80206, (303) 666-4357

12/0294

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2/0195

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INNOVATIONS SHOULD BE PATENTED if marketable. For more information call Brian Smith of "Fields, Lewis, Rost, & Smith". Colorado's leading patent law firm. Mr. Smith specializes in the medical arts. (303) 758-8400. 12/1294

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♦ MISCELLANEOUS

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"Alzheimer's Disease Resource Directory"

If you have patients or care-acquaintances concerned with disease, the Denver Regional Governments (DRCOG) has available to the public a 24-page booklet called "Alzheimer's Disease Resource Directory". obtain the booklet, sons can call the council's Aging Division at 455-

Most who are concerned with disease are with so of a non-such as con-di-

is not in-directory of gives the history of estimated 48,000 per-is now considered to be the among adults, taking more than

givers among your Alzheimer's Council of made free the To per-Services 1000. people rectly with the confronted many problems medical nature, financial and legal siderations. This rectory is the result of discussions and fact-gathering by members of DRCOG and by the Alzheimer's Association. It tended to be a "medical" any sort, even though it also the disease which afflicts an sons in Colorado. Alzheimer's's fourth leading cause of death 100,000 lives annually.

Alzheimer's Disease

Resource Directory



RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

*The Last Words of Socrates:
"I owe a cock to Asclepius;
will you remember to pay
the debt?"*

I go through life making notes to myself . . . mental notes, scribbled notes, picture notes, blank-piece-of-paper notes (when I get out of the car and don't have time to write a note, I leave a piece of paper stuck on the steering wheel or lying in the seat to remind me of something).

If I read something that I particularly like or that strikes a pleasant mental chord, I make a note of it. Later, when I am doing something totally unrelated I will find these notes. That's where Socrates came into the picture; he was always a favorite of mine.

When I taught communications, I made great use of the Socratic Method: teach by questioning. Most people think that this is not a method as much as it is the fact the teacher doesn't know what he's supposed to be teaching, so he asks questions of the student: when a seemingly rational answer is elicited, or an answer with which the teacher can agree, then the student is credited with learning.

To me, effective verbal communication consists of equal amounts of speaking and listening. One of the most effective methods of prompting communication is by questioning. I have found through life that I ask many questions only for the sake of prompting some reaction, because there are those times when the answer is self-evident or just plain common sense.

I find, more and more often, that I am talking to someone who has an overwhelming need to be recognized for something. . . anything. They are effusive. This reminds me of another note I made some time ago:

Wear your learning, like your watch, in a private pocket: and do not pull it out and strike it, merely to show that you have one.

**Philip Dormer Stanhope
Earl of Chesterfield**

Thank goodness I remembered to make notes or I would have forgotten where I was going with this before I finished writing it down.

Back to Socrates: I was reminded of him because these are my last words for 1994. Wouldn't it be easy, I thought, if I could just end the year by saying "I owe a debt to so-and-so. . . will you remember to pay the debt (for me)?" However, since I plan on being very much around in 1995, I can't do that because of another note I made about ethics:

The generality of men are naturally apt to be swayed by fear rather than by reverence, and to refrain from evil rather because of the punishment that it brings, than because of its own foulness.

Aristotle

You see, Socrates knew he wasn't going to be around; like he was outta' here, body and soul, so he wasn't worried about ethics... he was only worried about his good name after he was gone. I guess the safest way to end the year in communication is on a note of nostalgia. . .

*I lift my glass in a grateful toast
To those glorious days of the
used to be ...
Days that live on in memory,
Bathed in a shimmering golden haze...
Our still-remembered "olden days"!*

John Irving Dillon

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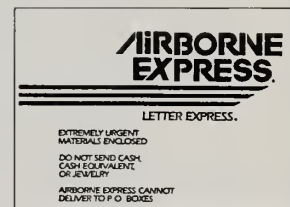
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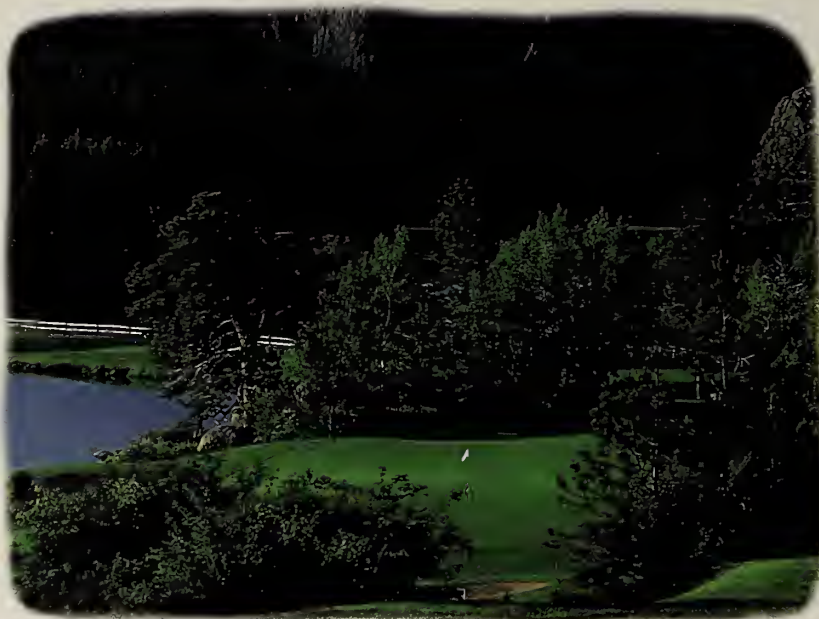
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February, 1995

Volume 92, Number 2

A few Good Doctors Wanted
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- Patient Access and physician fairness Joel M. Karlin, MD
- Being a Medical Volunteer Overseas..... Robert E. Eilert, MD
- Making Strides in Primary Care Education Richard D. Krugman, MD

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all you've
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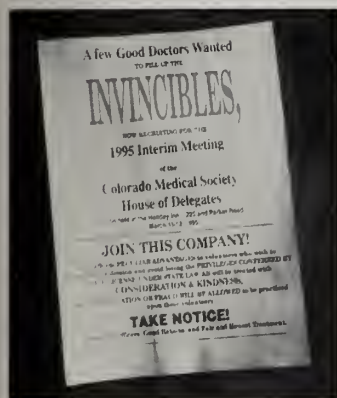
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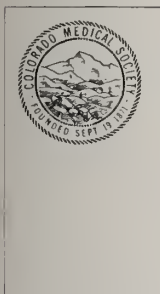
February, 1995

Volume 92, Number 2



Cover Story

How "invincible" is traditional medicine? The profession's very existence is threatened. The CMS Interim Meeting may be one of the last standoffs. You'd better be there!



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CMS Med Fax[®]

by **Montgomery Little and McGrew, P.C.**

legal counsel to the Colorado Medical Society

Help Get Legislation Passed That Will Require Safety Restraints For All Children

by Steve Berman, M.D.

The Colorado Medical Society strongly supports the passage of a bill requiring the use of restraint systems for the protection of children riding in motor vehicles. The sponsors of this bill are Senator Sally Hopper and Representative Ron May. The current child restraint law requires children under 4 years old and 40 pounds to use an approved child safety seat in all seating positions. In addition, Colorado's safety belt law requires drivers and front seat passengers to use a safety belt. However, children 4 years and older who sit in the back seat are not required to use a safety belt or safety seat under any Colorado law. This creates a gap in protecting children. Traffic crashes are the leading cause of death for Colorado children ages 4 through 15. While the death rate from traffic crashes for children less than 4 years of age decreased 34% after passage of the current Child Restraint Law, the death rate for Colorado kids ages 4-15 increased 26% during the same time period. During 1991-93, eighty-one Colorado children 0-15 years of age died while riding in cars; 70% of these children were not restrained. Among the unrestrained

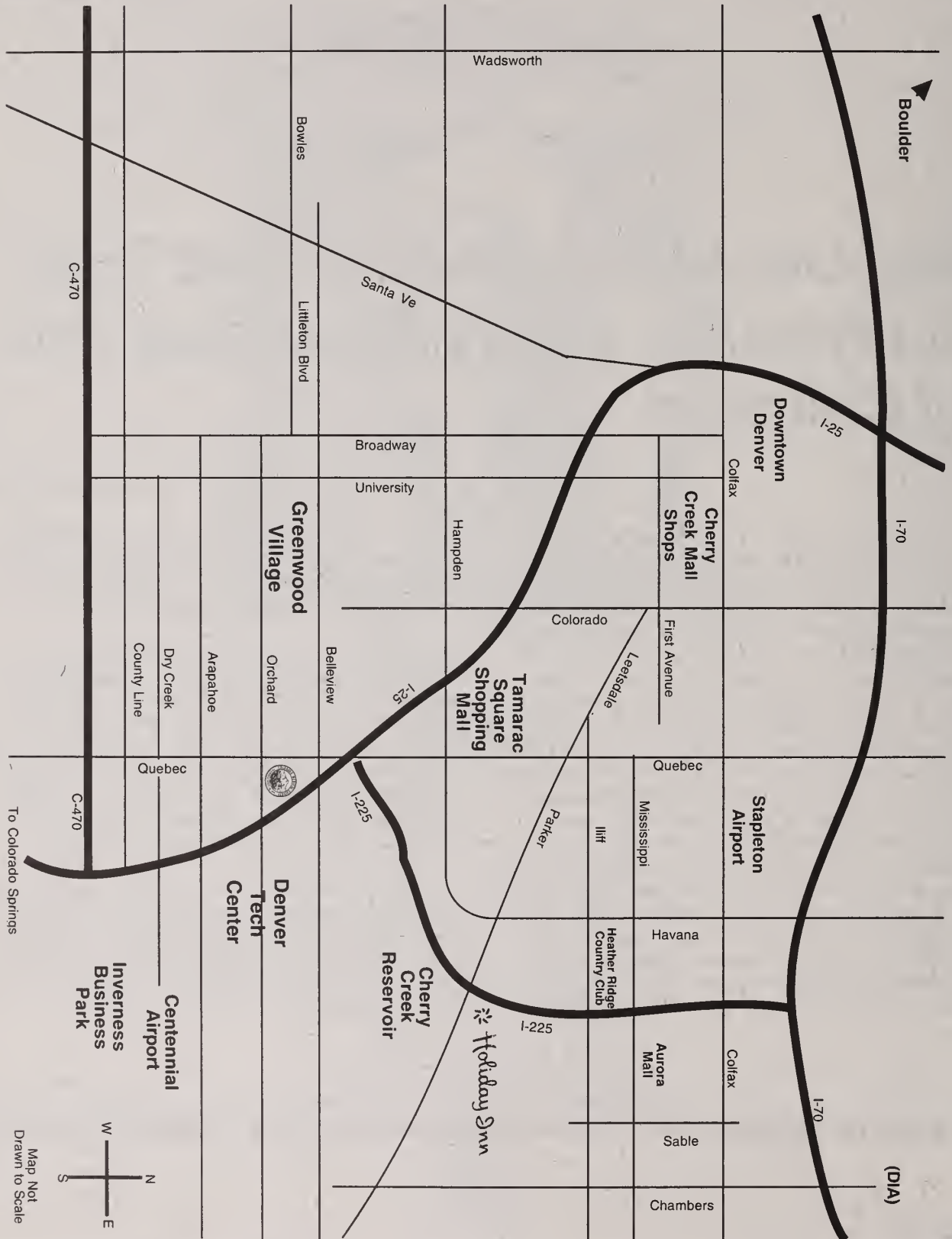
children, 24 were riding in rear seats. Safety belts do work in rear seats. Rear seat lap belts and shoulder harnesses have been proven to reduce severe injuries by at least 30% and fatalities by at least 24%.

The proposed legislation will improve the current child restraint law to cover children from 4 - 15 years of age; requiring the use of a restraint system in all seating positions. The driver will be responsible for passengers under 16 years of age. (The proposed legislation would exempt from the requirement situations in which 1) the rear seat is not fitted with safety belts or, 2) there are more occupants in a vehicle than seating positions with safety belts.)

The CMS believes that the proposed legislation will reduce deaths and severe disability among our children. Take the time to call your legislator at the Capitol. Leave a message on their voice mail. Ask them to support this legislation. Tell them it makes good sense to increase seatbelt use among our children.

See more legislative news inside on page 42 and following

Interim Meeting Map



Map Not
Drawn to Scale

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303-695-1700
FAX 303-745-6958

See Registration Info on Page 49

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Advisory Council on Health Programs for Women and Children

Regular monthly meeting.

For information call Suzette Clark at (303) 692-2421.

Colorado Dept. of Public Health and Environment

Educational conference for Medical Directors

February 25, 1995

U.S. West Learning Systems

3898 S. Teller, Lakewood, CO.

Keynote speaker is Dr. Steven Levenson- Maryland School of Medicine

Contact: Donna Zentner (303) 692-2886

American Management Association

OSHA and the Medical Industry: A Compliance Update

Feb. 21, 1995

Denver, CO. - Executive Tower Inn

Contact: 1-800-821-3919

American College of Cardiology

Second Annual Workshop on 2-D and Doppler Echocardiography at Vail.

February 27-March 2, 1995

Radisson Resort-Vail- Vail, Colorado

CME: 17.5 Category 1 AMA

Contact: (301) 897-2695

Medical Records Institute

"Toward an Electronic Patient Record '95: Eleventh International Symposium on the Creation of Electronic Health Record Systems and Global Conference on Patient Cards.

March 14-19th, Orlando, Florida

Contact: Leslie Campbell- (617) 964-3923

Presbyterian/St. Luke's Medical Center

New Developments in Cancer Biotherapy: the 2nd Decade

March 30-April 2, 1995

Beaver Run Resort, Breckenridge, Colorado

Contact: Mary Fletcher, 303-869-2244

HealthONE

Geriatric and Surgical Urogynecology

March 31-April 2, 1995

Beaver Run Resort, Breckenridge, Colorado

Contact: Mary Fletcher, 303-869-2244

Colorado Society of Osteopathic Medicine

Annual Meeting

June 16-18, 1995

Snowmass Conference Center, Snowmass at Aspen, Colorado

Contact: Patricia Ellis (303) 322-1752

American Association of Blood Banks

Ensuring a Predictable Donor Base: Marketing Models for the 21ST Century

September 10-12, 1995

Hyatt Regency Denver, Denver, CO.

Contact: (303) 295-1234





David C. Martz, MD
President, 1994-1995

On avoiding "Feckless"

Who among us cannot recall the challenge of vocational commitment that we faced in our high school or college years? Many of us were torn between multiple options: engineering, applied math, the fine arts, teaching, scientific research, business. . . and medicine. As we weighed the merits and limitations of each alternative those several (or many!) years ago, one of the attractions of medicine was the belief that it would be a secure career—come economic depression or inflation, war or peace, famine or plenty, physicians would always be needed.

Or so we thought then. Alas, how times have changed, and so rapidly so recently! Though medicine will always endure as a vital profession, as individuals many of us now face the uncertainties of career stability that formerly characterized only the professions we previously declined.

The advent of managed care as the key player in health care reform has eclipsed the impact of governmental intrusion. Born over twenty years ago as an innovative experiment in cost control, it has grown exponentially, and now has metastasized from its primary source and coastal implantation to nearly every community in the country—including our beloved and once sheltered Rocky Mountain utopia.

Peak Health has merged with

Lincoln National, then TakeCare, then CompreCare, and now FHP. Qual-Med has become HSI; PruCare, Aetna, Kaiser, CIGNA, MetLife, and untold others have taken root and grown. Our "rural state" is now 23% managed care penetrated overall, with some metropolitan areas up to 29%.

Hospitals are scrambling to survive. With excess beds and skyrocketing in-patient costs, they are struggling for their own economic survival by creating HPOs which insert them in the "food chain" at a high level of dollar division and diversion—at least parallel to physicians, and often well above our own link. And now they too are conglomerating frantically.

We have responded to this New Age of health care with more confusion than composure. Our individual choices have included denial, "shun them all", "join them all", retire early, change careers, join the military, grow groups without walls, create specialty cartels, and/or sell out to hospital systems.

With the diversity of issues from community to community, hospital to hospital, practice to practice, and individual to individual, no unifying strategy has emerged. Never in our profession has "divide and conquer" been more evident—or effective. Seemingly up to our necks in alligators, draining the swamp is beyond our control.

Or is it? Certainly this is no time for Feckless* Foolishness. Now is the hour when we must move quickly and effectively to protect the triumvirate of medical excellence, fairness to physicians, and choice for our

patients. This very month your Colorado Medical Society is working fervently on many fronts to meet the wide variety of circumstances that confront our colleagues.

- 1) We have negotiated a commitment with the HMO Association signed by the HMOs who control 80% of our managed care population in Colorado, which provides a new degree of fairness to physicians in regard to affiliation-disaffiliation issues.
- 2) We are initiating legislation to require that employers who offer HMO plans include a point of service option which would allow an employee to choose physicians not affiliated with the HMO panel. (See Dr. Joel Karlin's article, "Patient Access and Physician Fairness", which describes these two issues in more detail.)
- 3) The Colorado Hospital Association is forcing corporate practice legislation for the entire state. We are insisting on inclusion of due process for physicians and penalties for aberrant behavior.
- 4) The advance practice nurses are pushing for expanded scope of practice. We are requiring that this occur only in the setting of Collaborative practice with physicians, including oversight by the Board of Medical Examiners. "Independent" practice by advance practice nurses is unacceptable.
- 5) Integrated delivery systems will be the theme of our Interim Meeting in March and a major focus of the Health Affairs

Council over the next year, in an effort to assist those of you facing complex choices in PHO (or HPO) settings.

- 6) And, we are moving ahead with exploration of establishing a Colorado Physician Network, thanks to the now voluntary contribution of almost \$140,000 by a sizable segment of our membership. A Board of Directors of that transitional corporation (separate and distinct from Colorado Medical Society) has been named. By the time this publication reaches you, a

consultant will have been selected from the four finalists, and we will be deep into the analysis of structural options, market feasibilities, and methodologies. Should the Colorado Physician Network appear to be viable, a product may be defined and offered to you in the next three to six months. Emphasis will be placed on medical quality rather than financial profiteering, and the goals will include a much more inclusive physician panel than current plans provide.

No, this is not the time for feckless leadership or fickle commitment. We must support each other in the days ahead, regardless of which facet(s) of need apply to each of us as individuals. For Colorado Medical Society to serve you, we must join forces, share insights and vision, take reasonable risk, and commit to problem solving.

Fear and fragmentation would render us feckless, while diversity, diligence, and a sense of destiny will give us power!

***Feckless:** *adj., ineffective; worthless; irresponsible.*

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000

Liability Exposure under the Health Care Availability Act

The Health Care Availability Act (HCAA) was enacted by the Colorado Legislature in 1988. The statute provides that the total amount recoverable in a malpractice case shall not exceed \$1 million, present value, and indicates that not more than \$250,000 shall be attributable to noneconomic loss, defined as pain and suffering, inconvenience, emotional distress, and impairment of the quality of life. Another statute indicates that there is no limit on the recovery of damages for physical impairment or disfigurement. It is debatable whether the \$250,000 noneconomic damage ceiling included in the HCAA includes damages for physical impairment or disfigurement.

There are exceptions to the \$1 million ceiling in the HCAA. The court may determine that the value of lost past and future earnings or past and future medical costs may, when added to the value of other future damages, exceed the \$1 million.

Periodically, claimants seek an award of punitive (punishment) damages against a health care institution or professional. To prevail on such a claim, the plaintiff must prove that the actions of the health care professional or institution were attended by circumstances of fraud, malice, or willful and wanton conduct. It would appear that the \$1 million ceiling would also be applicable to a claim of punitive damages. It is critical to remember that punitive damages are not covered by insurance, and most often independent counsel is hired, if there is a punitive damage claim. Often this

"independent" counsel will confer with the health care professional or institution's insurance carrier to try to encourage settlement within policy limits. Generally, the amount of punitive damages cannot exceed an amount which is equal to the amount of actual damages awarded to the injured party unless it is shown that the defendant has continued the wrongful behavior or repeated the action which is the subject of the claim against the defendant or has acted in a willful and wanton manner during the pendency of the action, which has further aggravated the damages of the plaintiff, when the defendant knew, or should have known, such action would produce aggravation.

If a damage claim has been asserted against a health care practitioner or institution, it is important to determine whether the damages fall within the category of (1) noneconomic damages (with a statutory imposed cap), (2) disfigurement or impairment (which may well not have a statutory cap), or (3) economic damages (which do not have a cap). If punitive damages are ultimately alleged, or the possibility of such offering exists, it would be wise to consult with independent counsel promptly to try to reach a prompt resolution of the claims within the insurance policy limits.

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EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society

Physicians have a valid, effective legislative process within organized medicine by which they can influence federal and state health care legislation, national and local public opinion, even standards of care. Physicians, however, need to participate in this process to keep it effective. This is a vital role.

If you ever thought being an elected officer of the American Medical Association is just fun and games for the rich and (wannabe) famous, let me disabuse you of that thought. The physicians who accept offices with the AMA must be willing to stay up-to-date on every medical issue; they must stay in touch with their constituents at home; they must remain aware and involved in the political processes of their home town and state, to know what the likely medical issues will be. In addition, they must stay active in their local and state organizations to further sample the attitudes and feelings of their peers. They must fairly represent their own practice specialty interests, their component and state medical society, their group members or partners and their patients.

I am pleased that Colorado Medical Society has three such physicians who have given much of their time and energy to the legislative objectives of organized medicine. And now they are about to take another giant step in keeping the process alive and effective. They are candidates for membership on the councils of the American Medical Association, where they can have an even louder voice in national medical affairs, and additional

persuasive power for the good of patients and physicians.

The Colorado physicians and offices they seek are:

- **Eugene D. Jacobson**, Council on Scientific Affairs
- **Richert E. Quinn**, Council on Constitution and Bylaws
- **Richard Allen**, Council on Medical Education

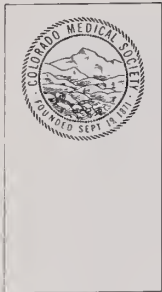
Already, all three give much of their time to matters of organized medicine. Rich Quinn is the senior AMA Delegate from Colorado, Gene Jacobson is the American Gastroenterological Association Delegate to the AMA, Richard Allen is chairman of the CMS Council on Legislation.

In addition to these three, **Joel M. Karlin**, CMS President-elect and AMA Alternate Delegate, seeks appointment to the AMA Council on Legislation.

CMS is very fortunate to have physicians who can give of their time and effort at this level of commitment. The pay isn't much (none), and the rewards are almost entirely the personal feelings of accomplishment. A large part of the payoff has to be their fellow physicians' appreciation for representing them. I hope you won't forget this and will let them know that you do appreciate what they do, because they are all very serious about their jobs in organized medicine, and about the necessity of physician representation at all levels of health care policymaking. The roles they play are vital to the medical profession.

Be glad you have someone willing to step forward to take on the job.

"... take heed and participate in the legislative process ..."



THE LOBBY



Richard Allen, MD
Chairman, CMS Council on Legislation

We're off and running! The Legislature has convened and committee assignments made. CMS is pleased, for the most part, with election results. After holding a number of meetings with newly elected or reelected legislators in their districts in the fall, we feel good about the composition of the legislature and the assignments. We've also held a number of strategy sessions regarding patient access legislation that we might want to introduce. The AMA's Patient Protection Act contains the elements that we feel are important to physicians and patients, particularly preserving patient choice and the fairness issues such as affiliation/disaffiliation from managed care plans. However, because of bills which were passed last year, particularly HB1193 which set up health purchasing cooperatives, it was felt that the legislature would not be receptive to any major health reform bills. We met with the House Majority Leader, Representative Tim Foster, to discuss these issues and felt that our best chance of success would be a requirement for point-of-service options in managed care contracts. Indeed, the market place has already responded to a large degree. With a point-of-service option, patients who are enrolled in a managed care plan could still be allowed to go out of plan to continue their care with a physician of their choice as long as they were willing to pay an additional co-pay for that option. A further step down that line

would be to require businesses to offer two or three (double or triple) options to their employees, for example, an HMO plan, a PPO/IPA plan, or an indemnity plan. The effort behind all this is to help patients continue an already established patient-physician continuity of care. The public has repeatedly stated that they want to be able to see the physician of their choice. Hence the slogan: **"My Doctor/My Choice."** Legislators, ever mindful of what the voters want, have been receptive to this as long as it would not adversely affect health care costs. Since it would be the patient who would opt for this choice (and thus be responsible for the co-pay), there should not be an adverse economic impact on business. By the time you read this we hope we'll have a bill in committee waiting to be heard.

A second issue has been the sunset review of the Medical Practice Act and the Nurse Practice Act. These were assigned to a joint House-Senate committee to work on over the summer and fall of '94. CMS was very involved in meeting with the other affected groups, primarily the nurses, to reach areas of agreement and assure continuance of these Acts. We had thought that everything was being worked out amicably, but the final draft of the Nurse's Act needed some last minute amendments. This was further complicated when the House HEWI Committee decided to hold a hearing two weeks ahead of schedule -- before anyone would have had time to have a final meeting. The main issue centers around proper oversight by the BME in making certain the

collaborative agreements are being observed. As of this writing, the issue is not yet decided, but hopefully will be resolved by mid-February.

A third major issue involves a bill submitted by the Colorado Hospital Association (CHA) to expand the corporate practice of medicine. As you may recall, last year a bill was passed that would allow hospitals in cities under 100,000 population to hire physicians. CHA would now like to expand this to include all cities by removing the population number. The CMS House of Delegates developed a policy statement on corporate practice of medicine and had asked CHA to include some safeguards for physicians. Without these safeguards we must oppose this bill. Thus we have offered some suggested amendments which we hope CHA will accept.

We have had several presentations made to us, both pro and con, on Any Willing Provider proposals, but other than a pharmacy bill to allow consumer choice in filling prescriptions, no one has presented a bill yet. Other new bills which have just come out include a proposal from plastic surgeons on patient access and "Consumer Protection Standards" from the naturopaths. Since this is the first week of the Legislative Session, the avalanche of bills is just beginning. Later this month we should have something much more concrete to bring to our newly reformed Congress of Physician Specialties (COPS), and I'm certain next month's column will have lots of interesting "stuff".

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Fax (202) 225-7885

He did it! He retired. Well, sort of...



K. Mason Howard, MD, accepts gift and congratulations from Larry Thrower, President of Copic, at a surprise retirement party in December.

K. Mason Howard, M.D., CEO and Chairman of the Board of Copic Insurance Company, finally picked up the ring and walked off, retiring to do a special project for Copic, but he says he is phasing out of the business over the next six months.

At least, on December 31, 1994, Howard's belongings were moved out of the office and he was making noises like someone having to pack up thirteen years of accumulation and get it out of the way of the new occupants.

In this case, the new occupant is Jerome Buckley, M.D., the new CEO and Chairman who has just ended full-time practice assumed the position at Copic. "Mase" Howard will be officing with George Dikeou, member of the Copic Board and legal counsel to the firm. Dikeou & Associates' law firm is at 5575 DTC Parkway, former Copic headquarters building. No, he is not joining the law firm; Dr. Howard will be using the office part-time to complete his project.

There is reportedly going to be a lot of golf in Dr. Howard's retirement schedule, and if the weather doesn't permit in Colorado, he'll probably go find the right climate. Actually, Jane Howard is working on planning some extensive travel for them, starting later this year. She's busy right now with her own project, the Fort Logan Historical Society.



Pat Schultz (r) presents Dr. Howard with special going-away gift from Copic staff.



Present for the surprise party were two special guests, Jane (Mrs. K. Mason), and Mase's father, Mr. Ken Howard

Colorado Medical Society

Tentative 1995 Interim Meeting Schedule

To be held at the CMS offices:

FRIDAY, MARCH 10, 1995

11:00 am - 1:00 pm	Finance Committee
1:00 pm - 5:00 pm	Board of Directors

To be held at the Holiday Inn Southeast (Parker Road @ I-225)

FRIDAY, MARCH 10, 1995

6:30 pm - 9:00 pm	Women in Medicine
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SATURDAY, MARCH 11, 1995

6:30 am - 5:00 pm	Registration
7:00 am - 10:00 pm	Office open
7:00 am - 8:30 am	Reference Committee Members
7:00 am - 9:00 am	Nominating Committee Open Forum
8:30 am - 9:00 am	Credentials Committee
9:00 am - 9:00 am	House of Delegates - Opening Session
9:30 am - 11:45 am	General Membership Meeting
-	Keynote:
12:00 N - 2:15 pm	Luncheon— Integrated Delivery Systems Panel discussion
2:30 pm - 5:00 pm	Reference Committee on Board of Directors/Constitution, Bylaws and Credentials
4:30 pm - 6:00 pm	Reference Committee on Health Affairs

SUNDAY, MARCH 12, 1995

6:30 am - 11:00 am	Registration
7:00 am - 12:00 N	Office open
7:00 am - 8:30 am	Arapahoe caucus
7:00 am - 8:30 am	Aurora-Adams caucus
7:00 am - 8:30 am	Boulder caucus
7:00 am - 8:30 am	Clear Creek Valley caucus
7:00 am - 8:30 am	Denver caucus
7:00 am - 8:30 am	El Paso caucus
7:00 am - 8:30 am	Larimer/Weld caucus
7:00 am - 8:30 am	Pueblo/Western Slope caucus
8:00 am - 8:30 am	Credentials Committee
8:30 am - 12:00 N	House of Delegates - Closing Session

Call for Nominations

The Nominating Committee will meet during the Interim Session in March to consider nominations for President-Elect, Speaker and Vice-Speaker of the House, two AMA Delegates and two AMA Alternate Delegates and any other offices of the Colorado Medical Society. All persons being considered for elective office must be cleared through this committee. This includes those who will stand for reelection. If you desire to run for office or to nominate someone, please contact Mary Lee Johnston at the Colorado Medical Society (303-779-5455 or 1-800-654-5653) or Dr. Barbara Reed, Chair, CMS Nominating Committee, 2200 E 18th Ave., Denver CO 80206, (303-322-7789). Make this contact as soon as possible so that the committee can properly prepare its report to the House of Delegates.

**This portion goes
to CMS**

Interim Meeting Registration

1995 Interim Meeting of the Colorado Medical Society, March 11-12, 1995, Holiday Inn Southeast

Name (*Please type or print*) _____

Name of Spouse/Guest (if attending) _____

Component Society _____ Office Phone _____

RESERVATIONS FOR EVENTS AND MEETINGS

(*Reservation deadline is February 24, 1995.* Reservations accepted on a first-come, first-served basis)

Number of
Reservations _____ Amount
Enclosed _____

SATURDAY, MARCH 11, 1995

12 Noon-1:30 pm Luncheon _____

Complimentary _____

HOTEL RESERVATIONS

Please use the hotel reservation form below to make your reservations directly with the Holiday Inn Southeast. **The deadline for room reservations is February 26, 1995.** The preferred rate will be extended to CMS members on a space available basis after February 26.

MEETING REGISTRATION

Please submit a registration form by February 24, 1995, if you plan to attend this Interim Meeting. We're delighted to receive it by mail, fax, or phone. We can check you in more quickly and efficiently if you've preregistered, in addition to providing more accurate and therefore cost-saving guarantees for our food functions. Thanks!

MESSAGES

For your convenience, a message board will be provided at the CMS registration desk. The hotel's phone number is 303-695-1700. (You may want to leave this number with someone.) If you need to be contacted, ask the hotel operator to transfer the call to the CMS registration desk or CMS office.

WHAT TO DO

Complete this entire form and return it to Colorado Medical Society, by mail to: PO Box 17550, Denver, CO 80217-0550, by phone to: 303-779-5455 or 1-800-654-5653 or by FAX to: 303-771-8657.

**This portion goes
directly to the
hotel**

Hotel Reservation Form

Colorado Medical Society
Interim Meeting
March 11-12, 1995

Please Reserve _____ Rooms for _____ Person(s)

Name _____

Firm _____

Address _____

City/State _____ Zip _____

Will arrive on _____

Day _____ Date _____ Time _____

Will depart on _____

Day _____ Date _____ Time _____

Credit Card _____

Name _____ Number _____ Exp. Date _____

Type Room—

Single 1 person \$64

Double 1 Bed 2 persons \$64

Double 2 beds 2 persons \$64

Suite \$95, 100, 110

Extra Charge per person _____

No. Persons Adults _____

Children _____

Check One

☐ 6 pm

☐ Guaranteed

Estimated time of Arrival at Hotel _____ Sharing with _____

Current lodging tax is 11.8%. Group cutoff date is 2/26/95. Reservations will be held until 6:00 pm Denver time, unless accompanied by a first night's deposit or guarantee of payment to a major credit card (please include expiration date). CHECK IN TIME IS 3:00 PM, CHECK OUT TIME IS 12:00 NOON.

Return form to:  **Holiday Inn**

Attn: Reservation Department
3200 S. Parker Rd.
Aurora CO 80014

Or Call: 800-962-7672



AMA UPDATE



Richard E. Quinn, MD
Senior Colorado Delegate
American Medical Association

The highlight of the opening session of the 1994 Interim Session of the AMA House of Delegates was the "fairy tale" account of the Federal Government's attempts at accomplishing comprehensive national health care reform during the past year. The account, given by Dr. Robert McAfee in his Presidential Address, was hilarious. (See **"President's Letter,"** David C. Martz, M.D., *Colorado Medicine*, Vol. 92, #1.)

The Association reported that reserves have shrunk to \$115 million over the past several years due to decreased revenues related to pharmaceutical advertising cutbacks and increased expenses in the promotion of Health Access America and attempts to influence health care reform. As points of reference, the AMA has approximately a \$200 million operating budget and reserves that approached \$150 million several years ago. An organizational restructuring has been undertaken to get more "bang for the buck." Layoffs of about 100 full time staff are anticipated. Restoration of profitability is anticipated in 1995.

The opinions of the Council on Ethical and Judicial Affairs on several issues were challenged, although the House did reject a resolution that required House approval of the Council's opinions. The Council's recommendations regarding physician use of pharmaceutical samples was again returned to the Council for reconsideration. Likewise the Council was asked to look again at physician treatment of family members and at its opinion approving the use of organs from anencephalic infants.

Managed Care Issues took up much of the House's time. The AMA will still strongly support the Patient Protection Act. A lengthy Board Report was extensively debated and passed with minor modifications; the report defines a role for the Association as a managed care counsel for physicians. It defines four principles to guide AMA efforts:

1. Professionalism-Medical Science and Ethics
2. Patient and Physician Autonomy
3. Patient and Physician Rights
4. Practical Assistance to Physicians

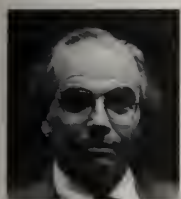
Positions were defined on financial incentives, postoperative services, subspecialist consultation, board certification, residency training, medical consensus, physician/patient decision-making, physician contracts and services, patient education, and population based practices as they relate to managed care.

The AMA has taken the tack of seeking an incremental approach to health system reform, mirroring the apparent mood of the country as reflected in the recent Congressional elections. Liability reform, insurance reform, anti-trust reform, quality enhancement, preservation of funding for Medicare and Medicaid, voluntary purchasing groups, Medical Savings Accounts, a choice of plans, and regulatory reform are to be advocated. The controversial subject of the Association's position on employer mandates has been modified to encourage individual ownership and choice of insurance as a complementary position to achieve universal access and coverage. The House also called for the

repeal of the insurance industry antitrust exemption under the McCarran-Ferguson act, although some pointed that this exemption would then be no longer be available to physician-owned or controlled entities.

All in all, I would say that the meeting was a microcosm of national political events, with conservatives asserting themselves more forcefully than in other recent meetings. The AMA continues to be physicians' most powerful advocate. Even though physician financial and moral support of their national representative body seems a given during this time of radical change in health care policy and delivery, only about 41% of practicing physicians are members of the AMA. The AMA is democratic. Doctors should be involved in policy formation at a grass roots level, and they can be.

Your AMA delegation wants to hear from you so that we correctly represent your viewpoint. This can only be accomplished if you are involved at a local and state level. I hear a lot of complaining about how events are influencing the practice of medicine, and I couldn't agree more. I must admit that it irritates me when some of the most vocal critics of organized medicine don't even support or participate in the process. This is a plea to CMS members who don't belong to the AMA. I especially want to address younger physicians, who seem largely apathetic to organized medicine, as reflected in membership studies; the future of this profession is yours, for better or worse. Get involved and help shape that future.



Mark A. Levine, MD
Colorado Delegate
American Medical Association

Outrage and courage were the highlights of an emotional meeting of AMA's Hospital Medical Staff Section (HMSS) late last year in Honolulu.

Outrage was the response to the weakened role for Medical Staffs in the 1995 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation standards for quality of care. The new standards hold the Hospital Board responsible for clinical quality without outlining a specific role for the Medical Staff. Outrage was also expressed over the JCAHO's decision to proceed with public disclosure of hospital specific performance data.

A resolution demanding that the AMA consider withdrawing from, or at least scaling back its involvement in, JCAHO was passed by the HMSS and was forwarded to the full AMA House of Delegates where it was accepted, thus becoming AMA policy. The JCAHO had apparently been anticipating the outrage of organized medicine. In fact, many of the onerous 1995 standards have already been modified, and medical staffs will again have greater control of the quality of medical care.

However, the JCAHO remains stubborn in insisting upon public disclosure of hospital specific data. This policy is strongly resisted by other health care organizations in addition to the AMA, as the American Hospital Association is also on the record in opposition. This presents a major threat to the mission and meaning of the JCAHO itself as it is now in direct conflict with two major organizations that contribute to its leadership. Stay

tuned, as we have yet to hear the last scene of this drama. It is possible that we will soon see either a quieter, gentler JCAHO or its replacement by a new accrediting agency devoid of representation from organized physicians or hospitals.

The courage of the HMSS was evident in the debate over a reorganization of the section. The section voted to extend its mission to include the interests of non-hospital medical staffs and will change its name to the Organized Medical Staff Section (OMSS). This was a very significant move for the HMSS as it marked a significant dilution in the representation of hospital medical staffs by adding representation from non-hospital physician organizations such as TPAs, FPOs and group practices.

Hospital medical staffs have been less able to represent physician interests in recent years. The JCAHO has maintained that the hospital medical staff operates as a delegated function of the Hospital Board and does not have an independent function. As such it is inherently unable to represent the sole interests of its member physicians. The medical staffs that do represent physician interests independent of hospital or other concerns are the non-hospital medical staffs of physician organizations. In recognizing this new reality, the AMA has given these new physician organizations direct entry to its policy and decision making process.

Hopefully, this transition will result in greater meaning and relevance to the actions of the section.

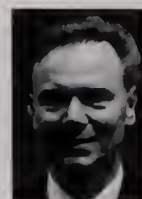
Goodbye HMSS. . . Hello OMSS

P

atient access and physician fairness

"...the agenda for CMS"

by Joel M. Karlin, MD
CMS President-elect



My Doctor... My Choice!

Physicians are smart, hard working people; they have to be in order to graduate high scholastically from college and be accepted to and complete medical school. They must be able to assimilate a multitude of information, process that information, and then reapply it to clinical situations.

When physicians know the standards by which they are judged, almost always they will adhere to those standards to the benefit of their patients and themselves. Such an assumption is based on the setting of fair standards known to the physician, and the collection and interpretation of appropriate data from which a physician can be judged. Unfortunately, some physicians have been inappropriately deprived of access to patient groups based on unknown standards and microanalysis of incomplete global data. Limited by contractual language in their managed care participation agreement, often such physicians have little recourse, and their patients lose the ability to see their physician. The matter has become acutely worse with the recent consolidation in the managed care industry, and the "right-sizing" of physician panels.

The leadership of the Colorado Medical Society (CMS) have been working for over two years to

develop a program to restore access to patients and fairness to physicians. That program started with discussions in the CMS Physician Patient Advocacy Council and has finally developed into a package of components, the implementation of which has just begun.

On January 13, 1995, Friday the 13th, at the CMS Board of Directors' meeting, CMS President David Martz signed "The White Paper on Physician Affiliation/Disaffiliation" which had been signed earlier that day by Mr. Mark Donohue, President of the Colorado HMO Association. This paper, the first of its kind in the United States, culminated one year of every other week negotiations between the Colorado HMO Association and Dr. Bob McCartney and myself, representing CMS. The document assures participation in the joint program of CMS and Colorado HMOs representing at least 80% of the covered HMO lives in the state. It takes the mystery out of the process of affiliation/disaffiliation of physicians by HMOs, and instills a system of fairness for physicians. Its features include:

- development and disclosure of contracting standards for primary care and each physician specialty which should be used in determining physician selection, retention, and disaffiliation from HMOs. Such standards would be developed in consultation with physicians within each specialty and primary care;
- development of specialty specific data collection and analysis in

consultation with physicians within that specialty and primary care; development of physician "Report Cards" for all physicians within each HMO, including data regarding the physician's performance within that HMO relative to stated criteria and to an appropriate group of comparable physicians;

- disclosure of the reason, including the criteria and methodology used by an HMO, when disaffiliation occurs because of change in network size or composition. Similar disclosure of reason for a physician's voluntary resignation from an HMO would be required;
- establishment of a voluntary mediation process to deal with such issues.

This agreement will hopefully end the fear physicians have when opening a certified letter from an HMO and learning of their 90 day "termination without cause". It will establish a system whereby a physician will know all along how he/she rates with each participating HMO. No longer will criteria for utilization and quality be developed without input from physicians who practice that same field of medicine day-in and day-out. This negotiated agreement will hopefully be the first of what promises to be many negotiated issues CMS will attempt with the Colorado HMO Association.

Having spent the last several years pondering over a potential solution to patient's inability to choose their physician, CMS physi-

Patient access and physician fairness (Continued)

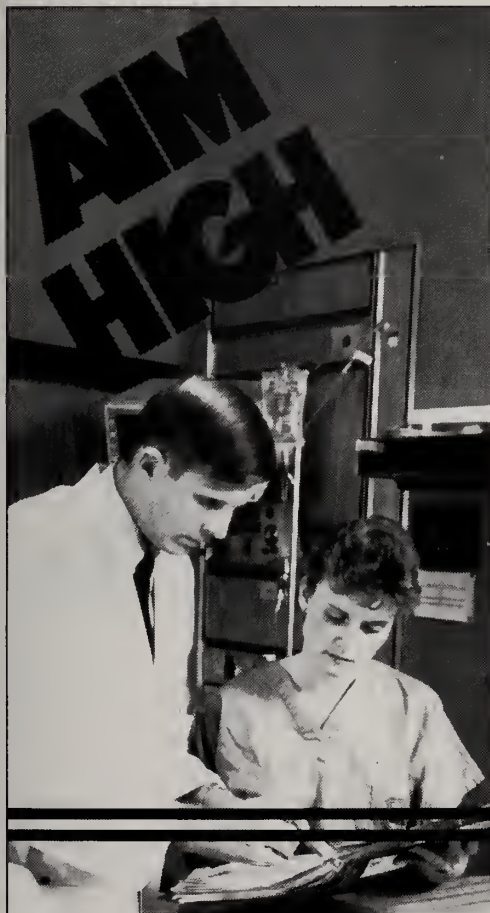
cian leadership believes it would be in the best interest of the patient, the employer, the health care system, and the physician, to uncouple the link between the employer and the individual in the selection of health insurance plans. Our Colorado AMA delegation introduced this concept to obtain coverage for out-of-network services through a "Point of Service" plan (POS). The insurance carrier would continue to determine health benefits included in their plan, and no additional benefits would be available through the POS plan. An alternative premium could be charged by the insurance carrier for the POS plan that takes into account the actuarial value of such coverage. Employers would continue to

determine whether to offer health insurance to their employees, and what part of the cost, if any, to pay. If the employee chooses the POS plan, the employee would bear that additional cost. Different co-insurance percentages and deductibles could be charged for in-network and out-of-network services. However, plans could not impose unreasonable cost sharing requirements which would place undue financial hardships on enrollees such that obtaining coverage through a POS plan would not be a viable option.

We believe that with implementation of "The White Paper on Physician Affiliation/Disaffiliation", and the passage of "The Colorado Patient Protection and Health Care

Fairness Act", CMS will have restored some degree of patient access and physician fairness. Very shortly, you will learn of the collaborative efforts of CMS with specialty societies, the formation of a collaborative effort with our patients through the newly approved CMS Patient Advisory Committee, and a CMS statewide marketing program for patient access known as the "My doctor, my choice" program. This is only the beginning of an energized, pro-active CMS.

The next time someone asks you, "What value do you receive from your CMS membership?" just smile and hand him or her this article. Then suggest they call 779-5455 and request a membership packet.



BE AN AIR FORCE PHYSICIAN.

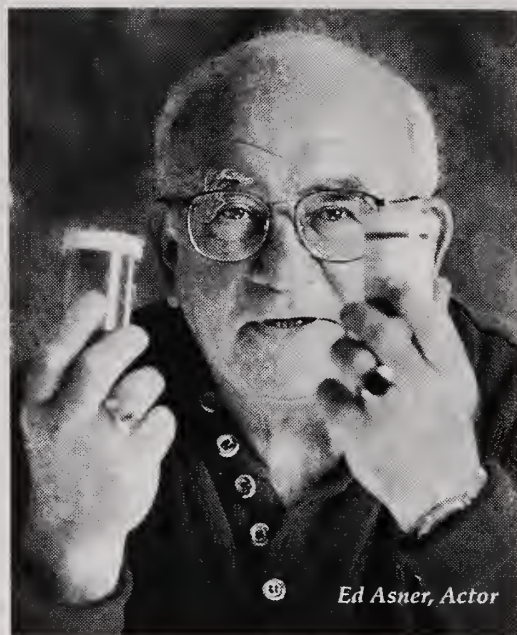
Become the dedicated physician you want to be while serving your country in today's Air Force. Discover the tremendous benefits of Air Force medicine. Talk to an Air Force medical program manager about the quality lifestyle and benefits you enjoy as an Air Force professional, along with:

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Attention: Physicians



Ed Asner, Actor

Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

The next time you prescribe a medicine, ask your patients:

"What other prescription and nonprescription medicines are you taking?"

A public service message from the National Council on Patient Information and Education (NCPPIE) and the U.S. Administration on Aging

Write for *free information* on patient medicine counseling.

OR FAX:
(202)638-0773

Mail to:

✠ ✠ NCPPIE
✠ ✠ 666 Eleventh Street, NW
Suite 810
Washington, DC 20001



Thomas R. Dunn, M.D.
Medical Director

CFMC Activities: Change is Good

In addition, CFMC is contracted to work with the Medicare Quality Indicator system (MQIS), which is a more structured, specified, science-based procedure to develop indicators of quality for specific diseases or procedures. MQIS supports the commitment to the development of methods for profiling processes and outcomes of care, and for data collection and analysis that will promote the use of continuous quality improvement methodologies by providers. MQIS is expected to address the major areas of quality access, appropriateness, outcomes satisfaction; the major types of - preventive, chronic, acute: in both the HMO and FFS arena; inpatient, outpatient. CFMC has developed the infrastructure to perform the tasks of project development evaluation, literature search, methodologic programming; initiation and implementation project data collection, analysis; and feedback communication and education. A key ingredient to quality improvement is "buy-in" collaboration with the physicians and providers. This may occur at a single hospital, be multi-hospital, statewide or multi-state. While we are aware that physicians and hospitals are involved in multiple quality activities, some self-generated and others formulated by JCAHO, parent organizations, specialty societies, or the Health Data Commission, CFMC often is unaware of specific projects of individual hospitals. Many of the requirements for JCAHO and other regulators could be mutually met by the Quality Improvement projects of

CFMC in collaboration with one or more facilities. Discussion has been initiated with the Medical Society and Hospital Association to establish a clearinghouse for activities of the institutions in order to maximize the effects and minimize the efforts.

Protecting and improving the quality of health care must be an explicit goal of any health system reform - at the federal, state and market place level. With or without healthcare reform legislation, there is a benefit from ongoing quality monitoring and improvement. A broad coalition of consumer health care and academic organizations support this concept. In the last congress, five Senate Committees endorsed the concept of these quality related activities integrated within a national quality management program and coordinated through a nationally directed but state-based network of Quality Improvement Foundations. Alternatives to this concept may perpetuate the emphasis on costs and the fragmented, duplicative, economically driven process we have seen in the past. To this end, the leadership of CFMC has begun dialogue with CMS leadership so that we might face the future with a better system. The overall concepts of continuous improvement are powerful, exciting, and doable by us, the providers and practitioners. Let us not forfeit this opportunity to the industry.

Introduction: Changes in the mission of CFMC

Redirection of our attention from the actions of a few outlier physicians and providers to improving the quality of mainstream Medicare health care is the theme of the work that the Colorado Foundation for Medical Care now does in the Medicare arena. The Health Care Quality Improvement Program (HCQIP) seeks to stimulate the involvement of physicians and providers (hospitals, nurses, pharmacists, etc.) in clinical practice improvement activities with emphasis on quality measures based on practice guidelines and outcome studies. Current projects (not an inclusive list) include Prostatectomy Trends; Back and Neck Procedures; Carotid Endarterectomy; Transfusion in Elective Surgery; Aspirin in Myocardial Infarction; Coumadin in Atrial Fibrillation; Blood Pressure Documentation in the HMO population; Angiotension Converting Enzyme (ACE) Inhibitors in Diabetes; and Angioedema in Patients on ACE Inhibitors.

Learning from early Canadian experience in health reform

by J. Bruce MacDonald*

Reprinted (with permission) from the September, 1994, issue of *The Actuary*, the newsletter of the Society of Actuaries.

United States health insurance

actuaries concerned about their plight under health care reform may find the history of actuaries involved in Canadian medicare helpful. Let's begin with a few caveats. "Medicare" will be used in this article with its Canadian meaning, a government run system of universal medical coverage, rather than the narrower use in the United States, referring to its current limited Medicare program.

Also, substantial differences exist between Canada in the 1960s, when Canadian medicare was introduced, and the United States in the 1990s. Most of the differences, however, are not Canada vs. United States as much as 1964 vs. 1994. Please keep in mind the differences in environment and in medicare plans when applying the Canadian experience to U.S. activities.

Canadian health reform in the 1960s

Health insurance was not as well developed in the 1960s in Canada as it is now in the United States. Fewer actuaries in all specialties existed then. Few health actuaries worked for consulting firms, and most Canadian companies in the health field also operated in the United States. No actuary was worried about his or her job becoming redundant.

As an example, I was in the group department of a middle-sized Canadian company in the 1960s, which also operated in the United States. Only two Fellows (one was the vice president whose prime interest was expanding the group operation) and several near-Associ-

ates were on staff who were responsible for group life and pension and group health. When part of the health insurance field in Canada was eliminated, it just meant we had more time for our other responsibilities.

Some of our initial assignments resulting from medicare's introduction were **making cost estimates for the program and estimating the effect on physicians' incomes**, both for the provinces and the medical profession. The Canadian Institute of Actuaries (CIA) was not involved in this work because it did not exist until 1965, when the implementation of Canadian medicare was well underway. Quebec is a partial exception to this, because it made greater use of actuaries. Claude Castonguay, a Fellow of the Society of Actuaries, played a prominent part in developing the Quebec system.

Overestimates by non-actuaries a costly mistake

Non-actuaries did some initial work that actuaries should have performed. A non-actuary made a projection of the Canadian population for the end of the century, estimating about 37 million citizens, a figure about 10 million too high. The population projections were made during the baby boom, and it was assumed that the "boom" would continue. They were not revised when the birth rate dropped drastically. **Hospitals were built based on this estimate and, as a result, there are now more hospital beds than needed.** This occurred even without allowing for improved medical techniques that have

shortened hospital stays. This contrasts sharply with the Canada Pension Plan (CPP), whose actuaries quickly revised demographic projections when the expectations changed. In fact, the CPP actuaries never counted on the baby boom continuing and used a net fertility rate as low as 2 live births per female through reproductive age as early as 1964. More involvement by actuaries in Canadian medicare probably would have resulted in better demographic forecasts.

Canadian medicare structure outlined

Under the Constitution, **Canadian health care is a provincial responsibility, funded in part by the federal government.** The federal government sets guidelines under the Canada Health Act, under which transfer payments are made. This act requires that:

- Administration be on a nonprofit basis by a public authority
- All necessary hospital and medical services be covered
- Services incurred outside of Canada be paid at the rate that would have been paid in Canada
- Coverage be universal
- Coverage be portable within Canada
- Coverage be accessible to all
- User fees, co-insurance, and deductibles are not allowed, and individual premiums, a type of deductible, are allowed.

Some provinces elected to cover services that were not required, such as eye refractions solely for prescribing glasses, services of chiropractors and similar health care professionals who were not medical doctors, and

Learning from early Canadian experience *(Continued)*

the full cost of coverage outside Canada. Some provinces established drug insurance ("Pharmacare") plans, although in most cases they were limited to residents age 65 or up, or who had low incomes. A few provinces established dental insurance plans for children. Not all these coverages were required under the Canada Health Act, so provinces could impose conditions that the Act did not allow and could make changes unilaterally without federal consent.

Many services not under medicare are included under private health insurance, usually called Extended Health Benefits. A partial list of these covered benefits may include:

- Glasses and eye infractions solely for prescribing glasses.
- Dental procedures in the dentist's office
- Semi-private or private hospital care
- Extra cost for services incurred outside Canada
- Ambulance service
- Drugs (except those prescribed while hospitalized)
- Services of physi-therapists, chiropractors, osteopaths, chiropractists, naturopaths, masseurs, podiatrists, and speech therapists
- Nursing care at home and most private duty nurses in hospitals
- Stays in convalescent hospitals and nursing care
- Laboratory charges incurred outside hospitals

While the market no longer existed for basic hospital, surgical, or medical insurance, a market still existed where health insurance actuaries could design and market health insurance. As health costs escalated, the provinces began cutting back on services not required under the Canada Health Act that they had originally elected to cover. Cutting back these services might transfer the claims to Extended Health policies, depending on the contract wording. So the health

insurance actuary had to make sure that private health insurance was not required to cover additional services without an increase in premiums and take the necessary steps to counteract this.

Missed Opportunities

Many other opportunities have evolved for health insurance actuaries in Canada, in the areas of cost containment, claims analysis, and designing managed care. I fear many of these opportunities have been missed, but for good reasons. Not many health insurance actuaries working for insurance companies have actively analyzed claims, but the greatest amount of claims under Extended Health policies have been for prescription drugs. Though this severely limits the claims health insurance actuaries can analyze, room for improvement and the actuarial touch remains. Underwriters have been inconsistent in their claims analysis, with some using sophisticated techniques and others using primitive methods.

Medicare authorities have a much greater opportunity to analyze claims, but unfortunately, few, if any actuaries, are working for medicare agencies, except in Quebec. As a profession, we have not pointed out the contribution we can make to medicare agencies.

Economics professor urges Canadian actuaries to get more involved

Jane Fulton, a professor of economics at the University of Ottawa, has completed some interesting studies on Canadian health claims. She has appeared on the Phil Donahue show and has been an advisor to Hillary Rodham Clinton. She spoke about her work, much of which has been corroborated by a recent study done by the Ontario Ministry of Health, at the CIA spring meeting in March. For example, Fulton found that hysterectomies are much more common in Winnipeg than in Toronto and in rural Ontario than in urban areas. For the other sex, prostatectomies were more common on the west coast than the east coast. Is this the

result of some environmental or genetic differences in the population, or is it a function of the per capita number of specialists, or some difference in medical theories and practice between the areas? She also found that many tests are performed whose medical value is questionable, and some even identify nonexistent conditions. Other procedures are used to prolong life for very short periods, while contributing negatively, if at all, to the quality of life. Fulton concluded her talk at the CIA meeting by urging actuaries to get involved in solving the Canadian medicare problems.

She was diplomatic enough to mention the contribution the profession could make to this field, not what it could have been doing for the past 30 years.

Actuaries could do more with their skills

Our training allows us to accomplish a great deal. We certainly know the effect that changes in practice or reimbursement methods have on incidence and cost of coverage. Actuaries are trained to put a monetary value on probabilities that affect human beings, and medicare in any form offers a great opportunity to do so. Actuaries should be able to suggest cost containment methods that do not reduce quality of care. I may be prejudiced, but I believe that actuaries have a better overall grasp of the problems than other professionals in the health field, including statisticians and physicians, who may focus too narrowly on their own specialty, and not really see the "big picture." Health care reform in the United States will certainly change the work of the health actuary, but there will still be work to do, and it may be even broader and more challenging. Actuaries should be able to influence the course of health care reform in the United States more than they did in Canada, and I hope they seize the opportunity that most Canadian actuaries missed.

** J. Bruce MacDonald, retired, does some consulting work for the Senior Citizens Secretariat of Nova Scotia.*

Prepared by the Colorado Medical Society Health Care Financing Department
 Edie Register, Director
 Marijo M. Parkin, Program Manager

Key: DP = Denver Post; CMC = Colorado Managed Care Newsletter; RMN = Rocky Mountain News; DBJ = Denver Business Journal;
 C/M = Colorado Medicine

A synopsis of Recent Affiliations (or acquisitions) and Mergers (as of 1/16/95)

- **Rose Health Care System** is seriously pursuing buyout talks with **Columbia/HCA Corp.**, the nation's largest for-profit hospital chain. If the deal goes through, it will become part of a metro-area network including **Aurora Regional Medical Center** and **North Suburban Medical Center** in Thornton. (DP 12/18/94)
- Both **Rose** and **Rocky Mountain Adventist** have withdrawn from their joint venture with **St. Joseph Hospital** and **Lutheran Medical Center** known as **Primera Healthcare**. That leaves **St. Joseph**, **Lutheran** and their affiliated physicians as the sole members of **Primera** (previously known as the Integrated Delivery Network or IDN). (DP 12/18/94 and DP 1/13/95)
- **HealthONE** continues to pursue discussions with **Columbia/HCA** and **Provenant Health Partners**, which owns **St. Anthony Hospitals North and Central** and **Mercy Medical Center**. **HealthONE** owns **Presbyterian/St. Luke's Medical Center**, **Swedish Hospital**, and **Aurora Presbyterian Hospital**. (DP 12/18/94)
- **HealthONE** and **Provenant** are becoming equity investors in a new HMO being launched by **Sloans Lake Managed Care**

(SLMC), one of the state's largest managed health care plans. The third partner is the **Adventist system**. SLMC did not give **Rose Health Care System** (a board member) an opportunity to invest, and dropped **Rose** from its provider network. **Rose** was replaced in the network with **Presbyterian/St. Luke's Medical Center**. (DP 12/18/94)

SLMC has not dropped the **Rose** affiliated **Cherry Creek Associated Physicians (CCAP)** from its network. CCAP members' inability to admit SLMC patients to **Rose** will complicate their relationship with SLMC according to Dr. Mel Klein, president of CCAP. (CMC 12/27/94)

- **Provenant Health Partners** and **Rocky Mountain Adventist Healthcare Corp.** have approved entering into negotiations after almost a year's worth of on-again-off-again discussions. They have set May 1 as a target date for a formal agreement.

A **Provenant-Adventist** alliance could become the powerful core of a healthcare system covering the north, west, central, and southern parts of the metro area, experts suggested.

A **Provenant-Adventist** alliance raises questions about what **HealthONE** will do in response to the combination. **HealthONE** has been talking with **Provenant**, but those negotiations are apparently dead. Experts are predicting **HealthONE** will strike a deal with **Columbia/HCA Healthcare Corp.** (DP 1/13/95)

- **Boulder Medical Center**, a 40-

physician multi-specialty group in Boulder, has become affiliated with **PhyCor** of Nashville, Tennessee. **PhyCor** also operates the **Southern Colorado Clinic** in Pueblo, **Greeley Medical Center** in Greeley and a small group in Ft. Collins. (CMC 12/27/94)

- **Kaiser Permanente's** plan to consider using **Lutheran Medical Center** as its second key hospital in the Denver area has been shelved. Doctors at **Lutheran** objected to the hospital agreeing to take on business from **Kaiser** which currently sends almost all of its patients to **St. Joseph Hospital**. (DBJ 12/23/94)

Children's Hospital has announced a new contract with **Kaiser** which will send all of **Kaiser's** pediatric admissions to **Children's**. Previously, **Children's** saw approximately two-thirds of **Kaiser's** pediatric patients. Colorado is the largest **Kaiser Region** without a **Kaiser** owned hospital. (CMC 12/27/94)

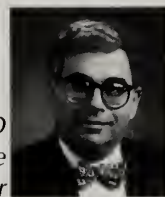
- **Health Systems International**, which merged with Pueblo-based **QualMed** earlier this year, disclosed that it received buyout offers from two rival California health maintenance organizations, **Foundation Health Corp.** and **FHP International Corp.**

Health Systems said the company is "not for sale in view of the favorable future prospects." A special committee of board members will consider the proposals, however, the company said. (DP 12/31/94)

M

Making Strides in Primary Care Education

Richard D. Krugman, MD
Dean, School of Medicine
University of Colorado Health Sciences Center



At a time when the pace of change in the health care system has made many Schools of Medicine moving targets, it's gratifying to report that the University of Colorado School of Medicine begins the new year on the heels of the most successful decade in history.

Research income rose to \$133 million in 1994, and several major centers have been developed in Cancer, Molecular Biology, Neuroscience and Aging during the past ten years. As a general pediatrician with a track record in rural health, perhaps the most personally gratifying development, however, has been on the education side, with the creation of the School's Generalist Initiative.

Five years ago, the Colorado legislature considered a bill that would have required the School "to ensure that 35 percent of its graduates would enter family practice".

Although the School ranked fourth in the U.S. in graduates entering family medicine at the time, the total was only 14 percent of each class. The bill was withdrawn after the School convinced the legislature that it was serious about graduating more primary care physicians.

A Generalist Initiative strategy was developed following the approval by the School's Executive Committee and Faculty Senate of the goal of 50 percent graduates entering primary care by the end of the decade. Among the key ingredients of that strategy:

- The Colorado Rural Health Scholars Program was started in 1991 by a first year medical student. For five weeks each

summer, 20 rural, underprivileged high school students participate in classes and laboratory experiences at the Health Sciences Center and clinical experiences at University Hospital. First and second year medical students serve as their counselors.

The aim is to interest rural students in medicine on the premise that they are more likely than urban students to enter primary care. The program has been a wonderful success. The students have shown a renewed interest in the health sciences, having previously been told by their school counselors that they would "never be able to compete" with urban or suburban students.

- The School's admissions process has been modified to support the generalist initiative by using a rural background as a "tie-breaker". This made sense since the literature suggests that there are three factors that are associated with choice of a primary care career: being older, being female and being from a rural area.
- Changes in continuing education have been implemented to include the addition of "locum tenens" coverage for primary care physicians who would like to take advantage of educational offerings at the School. Several rural physicians have already leapt at the opportunity to have someone cover their practice while they come in for further training.
- The most exciting feature is the initiative has been the launching of the School's Primary Care I, II and III course. Begun last August, it has

"... drawn rave reviews from students, faculty and primary care physicians."

Making Strides in Primary Care Education

(Continued from preceding page)

drawn rave reviews from students, faculty and primary care physicians. The course combines the didactic material of the introduction to clinical medicine with a new clinical component in which students spend a half day per week in a primary care setting. The aim is to provide all students with a generalist mentor as well as a longitudinal clinical experience in a primary care setting beginning with their first week of medical school.

Year one of the course focuses on patient interviewing and physical examination skills, supplemented with a curriculum on ethics, humanities and health policy. The second year will entail understanding specific medical problems and the

patient's stage of development and situation in life.

The community involvement in the development, implementation and evaluation has been sensational. Over 130 primary care physicians (general pediatricians, general internists and family physicians) from Kaiser, Denver Health and Hospital's clinics and private practices are currently hosting a medical student in their clinical setting three afternoons a month.

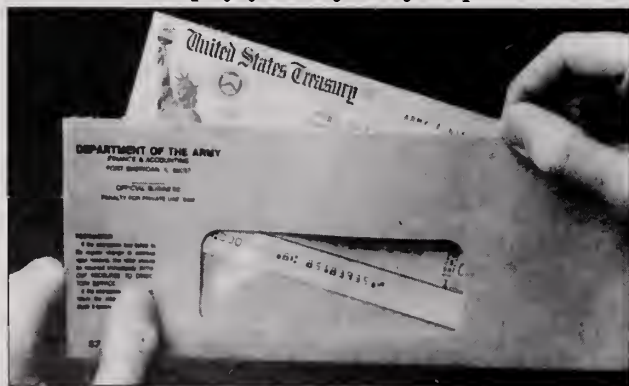
It is too early, of course, to assess the outcomes of our Generalist Initiative, but initial reviews have been favorable from a variety of divergent settings. The continued commitment and support of the primary care physicians will make the Primary Care I, II and III course

successful by providing early and frequent exposure to primary-care medicine in community settings. The first year students love the course. Further, the basic science faculty have noted that the students are more engaged and asking better questions this year than in prior years.

Politically, the School of Medicine now has the support of Family Medicine, as well as the Medical Society, and the verbal support of many state legislators. The true test may come this spring when we seek additional funding from the legislature for the initiative.

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by Stuart Silverberg, MD, Westminster, Colorado
reprinted from the Clear Creek Valley Medical Society Newsletter, January, 1995

Doctor Zhivago revisited

Those of you old enough to remember the prize-winning novel and the movie starring Omar Sharif that forced the author to flee Russia will recall that one of the main themes was the doctor's struggle to adapt to the "new social order" that altered his life as well as the practice of medicine in Russia following the revolution. As I travel across the U.S. and visit numerous clinics and practices, I have become acutely aware that medicine in this country is undergoing a major revolution. What bothers me most is the fact that we have been willing participants in this metamorphosis.

As government proposes radical changes, most of which never happen because of gridlock in Congress, we have hopped aboard a runaway freight train with the insurance companies at the controls, heading down a track with an unknown destination. We fight to get aboard this train, despite the fact that almost every doctor or health provider I talk to feels that the real problem facing us today is the insurance industry, not the delivery of health care. We have willingly pushed aside many of our colleagues in our rush to get aboard and get one of the best seats on the train to the unknown. Whether this is due to fear or to greed is hard to determine, but in the process we have abandoned many of our trusted working partners as well as our professional organizations.

One experience that brought this to focus was the reaction of a local county society in northern New

York. When several HMO groups came to their society 5 years ago to enroll the doctors, one old-timer stood up and eloquently exhorted the members to resist this invasion, and when he finished, the members stood up and cheered and walked out in unison. They succeeded in keeping any organized managed care out of the county until this year when the state mandated that a specified percentage of Medicaid had to be handled through HMO's. The upshot was that because of their boycott, they were able to pick and choose which HMO they wanted to work with for Medicaid and maintained a modicum of control.

By dividing us, the insurance companies have conquered us, and we are so subjugated that we couldn't convince almost 40% of the members of the CMS to commit a mere \$100.00 to attempt to form an HMO that would restore some control by all of the doctors in the state instead of a select few.

We have met the enemy and it is us (POGO). Remember, when you sell yourself to a large organization that limits participation, you become locked in when their subscribers reach a significant percentage of your practice. At that point, they can lower your fees, tell you how to practice, and virtually hold you captive to do their bidding. Maybe it is too late, but I would like to see the doctors return to their medical society and unite in order to save what sanity is left in this runaway ride down the track to "who knows where".

We have willingly pushed aside many of our colleagues in our rush to get aboard and get one of the best seats on the train to the unknown.

NOTES FROM THE FIELD

On being a medical volunteer overseas

Robert E. Eilert, MD
Denver, Colorado



This is a scene from the women's ward at Queen Elizabeth Hospital in Blantyre, Malawi. The young patient is in traction for a femur fracture which was a complication of psychodysostosis.

Malawi is a small country in south-east Africa that lies beside a large lake of the same name. Despite being explored by Dr. David Livingstone and ruled for thirty years by Dr. Hastings Kamuzu Banda, a medical school was opened just four years ago. With no local site for training, the few Malawians who qualified in medicine seldom returned to the country to practice. Dr. Ed Blair, a Canadian orthopaedic surgeon, first went to Malawi as a volunteer for the Rotary International program Malawi Against Polio. What he found was very little expertise in treating musculoskeletal diseases and no orthopaedic surgeon in the entire country of nearly five million people.

Dr. Blair decided the best way to change the quality of medical care was to educate middle level practitioners to staff the district hospitals as Orthopaedic Clinical Officers. A long line of orthopaedic surgeons from the United States and various

other developed countries has volunteered for a month at a time to help him. Under the sponsorship of Rotary International and Orthopaedics Overseas I worked as a volunteer in Malawi during November, 1994.

Practicing medicine overseas sounds like a stimulating experience, but we have plenty of needy people in our country. Why volunteer overseas? Initially, I was recruited to the program by Dr. Richard Kemme of Greeley, Colorado. He is the country coordinator for Orthopaedics Overseas and has worked six different sessions in Malawi himself over the years. Thinking back I realize I was ready for a break when I accepted Dr. Kemme's proposal to teach and practice in a far off African country for a month. My stress level at home was ten. In Malawi it was one or two. The people lived up to their country motto "The Warm Heart of Africa". They were friendly, receptive and happy to share their lifestyle with me. Their life is simple as the average family income is about \$300 per year, but they enjoy large families and rural existence, largely as subsistence farmers. The population has doubled to 10 million in the last 17 years, making the average age there about 15 years. There are lots of children everywhere. That was fine with me as I limit my practice in Denver to children's orthopaedics.

My job was to figure out how to best solve medical problems with the available resources. In general, the task was like stepping back thirty

NOTES FROM THE FIELD

years in the practice of medicine. I spent most of my time in Blantyre, a city of 400,000 and location of the medical school. I worked in the Queen Elizabeth Central Hospital that has about 100 orthopaedic beds. Many of the adults were patients in traction for a fractured femur as the standard treatment is for three months. I operated on two children with Potts paraplegia that we chose as the best candidates from those afflicted. There were cases of Burkett's sarcoma, Kaposi's sarcoma and other exotic diseases. I can barely spell schistosomiasis, but I had dinner with a guide who was just recovering from the disease. His colleague missed dinner altogether because he was shaking in the bathtub trying to break a malarial fever attack. You do have to take careful precautions for your own health, especially considering the high rate of HIV positive people. The nurse in charge of the blood donation program for the Q.E. was an expatriate volunteer. She told me that the blood she collected from workers at a factory in Blantyre the previous week was 60% positive on HIV testing.

Ed Blair has trained 45 Orthopaedic Clinical Officers in the ten years that the program has been running. I met them all at a special conference in the capital city of Lilongwe the first week I was in country. My role was that of visiting professor, along with a British orthopaedist who came over from Zambia. The OCOs presented their own papers, as well as cases for consultations. Their demonstrated

knowledge and outcomes impressed me with the success and impact of the program on the country. It was satisfying to be a part of the process. I would highly recommend the experience to any doctor who can take the time from practice.

For further information:

Health Volunteers Overseas,
Washington, DC, 202-296-0928
Dr. Richard Kemme, Country
Coordinator, Malawi, for Orthopaedics Overseas, 303-352-0250.



This is a scene from Zomba Central Hospital. One of the Orthopaedic Clinical Officers is about to set the fracture of a child's ankle.



SCAM OF THE MONTH

Preventing Prescription Drug Diversion and Abuse

In 1982, Colorado ranked among the top 15 states in per capita consumption of 9 abused prescription drugs.

The American Medical Association claims it is the "hidden" drug abuse problem in our nation. According to data collected by Congress, the National Institute on Drug Abuse, and the Drug Enforcement Administration, prescription drug abuse is the cause of more injuries and deaths than all illegal drugs combined.

In cooperation with the Colorado Prescription Drug Abuse Task Force, *Colorado Medicine* presents various Drug Diversion "scams" and offers possible solutions.

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1994-95

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Seasonal Back Pain Scam

Physicians should be alert to "professional patients" who have traveled long distances from their homes and who are adamant in their request for a specific medicine (**"It's the only thing that works for me."**) Such requests are usually for Demerol instead of Darvocet N-100, or Percodan or Tylox, instead of Tylenol #3.

Such scams seem to come in bunches, including attempts to secure prescriptions for Demerol, Percodan, Percocet, or Tylox, and usually involve ailments of a seasonal nature (**"I hurt my lower back cutting firewood... shoveling snow... etc."**).

The gang found operating in Missouri all lived at the same address and were all Medicaid recipients. They may have been professional wood-choppers or snow-shovelers, but given the number of physicians they were seeing over an extensive geographic area, it appears doubtful that they had much time for any legitimate work.

Solutions for this scam

1. Be aware that people who make a living at strenuous outdoor-oriented occupations usually seem to seek remedies other than pain medication for their aches and pains.
2. Be alert to several out-of-town patients with addresses in the same general area, particularly if they are all Medicaid patients.
3. Attempt, whenever possible, to prescribe non-narcotic analgesics for this type of ailment, especially if there is any suspicion regarding the true nature of the problem. If the patient agrees to additional tests to aid diagnosis, the probability of legitimacy increases.
4. Be aware of patients who appear to be overly familiar with the specific medication required for their pain.
5. Persistent demands for specific drugs should also be a warning sign, particularly for products such as Percodan, Percocet, and Tylox, which are basically the same drug.



Fall Symposium a Success

The Colorado ObGyn Society held its Sixth Annual Health Care Access Symposium, "The Effect of Health Care Reform on Women's Health Care; A 'Frontline' Panel Discussion" in November. The Symposium attracted an extremely diverse audience, including representatives from the American Association of University Women, the League of Women Voters, the Women's Agenda, the Domestic Violence Coalition, the National Conference of State Legislatures, as well as hospital programs, the Department of Health, Social Services, and many physicians from different specialties.

Comments from participants were very positive. Audience members came away from the meeting with a feeling that they were "up to speed" in regard to knowledge about health care reform on the state and national level, and, in particular, about managed care in Colorado. The participants were pleased with the many areas of health care that were covered, and were gratified that focus was placed on the issue of women's health care, and how best to provide quality care to women in the present health care climate.

The Keynote Address was provided by Dr. Steven Ringel, a member of Governor Romer's Health Advisory Panel. The dynamic panel was coordinated by Dr. John Sbarbaro, Medical Director, Mutual of Omaha. The panel consisted of Joan

Henneberry, Director, Women's Health Dept., Colo. Department of Health; Marshall Kaplan, Dean, CU School of Public Affairs, Ruth Aponte, Exec. Director, Women's Agenda; Alan Richman, Senior Partner, Law firm of Breit, Best, Richman, et al; Naomi Sullivan, Administrator, St. Anthony Hospital; Dr. Jerry Kopelman, Chair, Colo. Section, District VIII, American College of ObGyns; Meg Cleary, Vice President, Provenant Health Partners; Peggy Sandbak, Owner, Benefits consulting company.

The Society has won the Wyeth Award two out of the last three years, designating it the most outstanding ObGyn Society in the U.S., in part because of the outstanding community participation and partnership that has been forged through the annual Health Care Symposiums held each Fall.

We thank the following sponsors who helped to make this event possible: Ortho, Wyeth, Searle, Rose ObGyn Dept., Tokos, Parke Davis, TAP, King Soopers Corporate, Upjohn, and Berlex.

Teen Pregnancy Prevention Program

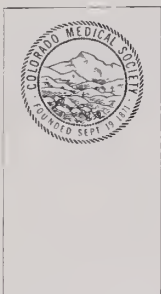
The Teen Health Education Committee continues to receive community requests for participation from ObGyn physicians. Members of the Committee are participating with the Colorado Trust on their significant efforts to prevent teen pregnancy, will be co-hosting a teen pregnancy prevention conference

with the March of Dimes, and will have an exhibit at the COAPPP conference, the statewide coalition group working to prevent pregnancy. The Speakers Bureau is presently working to schedule 16 requests, and a new set of posters will be available for ordering purposes by the end of the month. To request speakers or order posters, call Betsy Fox at 355-8884.

Legislative Events Scheduled

The Annual Legislative Breakfast is scheduled to be held March 3 at the state capitol. This is an opportunity to develop relationships with legislators, and to advocate on behalf of women's health. The Annual Legislative Dinner will be held March 20. This has become a favorite event for physician attendees as well as legislators. It will be held at the St. Francis Conference Center off of the Auraria campus, very near the capitol, for the convenience of legislators who wish to attend. This is another opportunity to create reciprocal relationships, and offer information concerning access for Colorado women to quality health care.

For more information, call Betsy Fox at 355-8884.



RETIREMENT

SSA Launches Customer Service Plan

Introduction: SSA assures "World Class Service"

The Social Security Administration is launching a customer service plan designed to assure that the public receives "world class service" as it moves into the 21st century, according to Tom Przytarski, Manager of the Denver office.

The plan consists of customer service standards developed as a result of customer service surveys, focus groups, interviews, employee questionnaires and discussion groups, and comment cards. The standards have been published in a brochure entitled "Putting Customers First". The standards will also be posted in all Social Security offices as a "Customer Service Pledge".

The effort is a result of the "reinventing government" initiative directed by Vice President Al Gore, and the resulting National Performance Review (NPR) plan. The NPR proposed setting a service goal for Federal agencies "equal to the best in business". Social Security Commissioner Shirley S. Chater stated that the agency's goal is to provide world class service. "This means that we will provide service equal or superior to that provided anywhere in the comparable public or private sector," the Commissioner stated.

"Here at the Social Security Administration, we are striving to define the characteristics of service that our customers expect from a world-class service provider and we are creating a goal that we use to chart our steps in the future," Przytarski stated. "SSA is looking for ways to do business differently and move toward the level of service the public wants."

Przytarski said that the standards are not intended to represent all that Social Security is doing, or needs to do, to provide world class service. "Rather, they are a small number of specific commitments that SSA is making now to address important aspects of service as identified in our customer and employee surveys. We are now in the process of determining what actions are needed to meet each standard and developing a means for measuring performance against each standard," the Social Security manager said.

The Standards are stated as follows:

We will provide service through knowledgeable employees who will

treat you with courtesy, dignity, and respect every time you do business with us.

We will provide you with the best estimate of the time needed to complete your request and fully explain any delays.

We will clearly explain our decisions so you can understand why and how we made them and what to do if you disagree.

We will make sure our offices are safe and pleasant and our services are accessible.

When you make an appointment, we will serve you within 10 minutes of the scheduled time.

If you request a new or replacement Social Security card from one of our offices, we will mail it to you within five working days of receiving the information we need. If you have an urgent need for the Social Security number, we will tell you the number within one working day.

The Social Security Administration will continue to ask customers directly about Social Security's service and how to make it better, according to Przytarski. "We will be using in-depth surveys and comment cards to find out how we are doing at meeting our customer service pledge and to get better information on what else we need to do to provide you with world-class service".

"Finally, our local office managers and the managers of our 800 number service can provide you with an easy way to tell them what you think of the service they are providing," he said. Comment request on by calling 1-800-772-1213.



Documentation Guidelines for Evaluation & Management

The Medicare Carrier, Blue Cross Blue Shield of North Dakota, will be conducting **Evaluation and Management (E/M) training workshops** to explain **Documentation Guidelines (DGs)** for E/M services.

Documentation Guidelines for the Physicians Current Procedural Terminology (CPT) E/M codes have been developed. These DGs are the result of a collaborative effort between the Health Care Financing Administration (HCFA) and the American Medical Association (AMA). The guidelines will be used to review medical records and determine the appropriate level of service for the E/M code.

Carriers of the Medicare program are responsible for educating physicians in the use of these guidelines and making physicians aware that these guidelines will be the basis of future carrier medical review.

Following the training period there will be a three month period, beginning April 30, 1995, during which physicians' billing patterns may be reviewed and further education can be offered. Thereafter, the Carrier is instructed to employ these guidelines in reviews.

It is very important that you know what the carrier is looking for

when your documentation is reviewed. If it doesn't appear in your records it wasn't done! Therefore, **it is vital that you attend.**

Remember, the medical review process can result in an overpayment calculated by the carrier, and the physicians must return the amount if the documentation in the medical record does not support the level of E/M codes reported.

With tremendous help from the county medical societies, the Colorado Carrier has already scheduled workshops in the Denver Metropolitan area and is now scheduling workshops in other areas. Watch for the Medicare newsletter and your county publications for workshop dates. Due to the rapid pace that these workshops are being scheduled, it is not possible to give much, if any advanced notice. Contact Edie Register at CMS for the latest information on workshops being scheduled.

Following is the schedule for Medicare workshops on **Proper Documentation of E/M Codes**. Six workshops were held in January at Denver area hospitals. Make reservations through your component society.

Schedule of Denver-area workshops on Documentation of E/M Codes

Day	Date	Time	Place
Thursday	Feb. 2	7:00 - 9:00 a.m.	Porter Memorial
Friday	Feb. 3	7:00 - 9:00 a.m.	St. Anthony North
Wednesday	Feb. 8	7:00 - 9:00 a.m.	Littleton Hospital
Thursday	Feb. 9	7:00 - 9:00 a.m.	Longmont United Hospital
Thursday	Feb. 23	7:00 - 9:00 a.m.	Avista Hospital
Tuesday	Feb. 14	7:00 - 9:00 am	Boulder Community Hospital

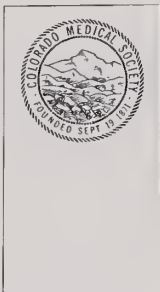
A Hidden Cost in Health Care Reform?

We all know the stories about the high cost of malpractice insurance, but now that doctors are working for HMOs, PPOs and the rest of the managed care alphabet soup, will the liability for the actions they take, the drugs they prescribe and the medical devices they use fall on the shoulders of the managed care companies that employ them? "Yes," says William B. Griffin, a partner in the San Francisco-based law firm of Brobeck, Phleger & Harrison. "Liability is shifting from the individual physicians to the large companies and medical groups they work for. These organizations are perceived by the trial lawyers to have far 'deeper pockets' than individual physicians, and we are predicting a tidal wave of lawsuits", Griffin said in an article in Medical Device & Diagnostic Industry. *SOURCES: Medical Device & Diagnostic Industry and Health Harbinger®*

Update on court challenge to RBRVS conversion factor

On October 7, 1994, the U. S. District Court in Denver held a hearing on a challenge by a group of physicians to the Health Care Financing Administration's implementation of the RBRVS. The physician group, led by M. Ray

continues on following page...



Painter, MD, alleges that the implementation process was not budget neutral, as required by law. Dr. Painter, a Urological Surgeon of Glenwood Springs, Colorado, is a CMS Delegate to the AMA House of Delegates. No decision has been reached by the court.

In January, 1995, the American Medical Association Health Law Division noted that "Dr. Painter and his associates are to be congratulated for bringing this case which, if successful, would benefit physicians across the country".

OSHA Compliance Issues

How to record bloodborne pathogen exposure incidents

When do employers need to record a bloodborne pathogens case in their OSHA 200 log? The blood borne standard has specific requirements for keeping records about those employees covered by the standard. But what about employees not covered by the standard who are exposed to blood? Are bloodborne pathogens incidents reported as an injury or an illness on the log?

OSHA has issued a number of memoranda and interpretations in an effort to eliminate confusion about recording requirements. This article pulls together several OSHA directives issued in the past two years in order to answer this question.

General reporting requirements.

Part 1904 of the Code of Federal Regulations (29 CFR) tells employers

when and how to report occupational injuries and illnesses. These requirements are explained in detail in an OSHA manual, *Recordkeeping Guidelines for Occupational Injuries and Illnesses*.

There are three main record keeping obligations. Employers must: record an injury or illness within six days on the OSHA 200 Log (or its equivalent), provide details of the incident on the OSHA 101 Supplementary Record, and post an annual summary of the OSHA 200 log. A few industrial classifications are exempt from the reporting requirements. In addition, any employer that had no more than 10 employees during the year is exempt from reporting. However, all employers must report fatalities or the hospitalization of three or more employees (from a single incident) orally to OSHA (29 CFR 1904.8) within eight hours. (This requirement went into effect in May, 1994.)

Recordable bloodborne incidents. An April, 1993 memorandum from the OSHA director of statistics to OSHA regional administrators provided guidance on reporting bloodborne incidents. According to the memo "...cases are recordable under 29 CFR 1904 when any employee experiences an 'exposure incident' ...that meets the criteria on page 6 of CPL 2-2.44C." (CPL 2-2.44C is the OSHA document that defines enforcement criteria for the bloodborne standard.)

For record keeping purposes, "exposure incident" is defined as "a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious mate-

rial..." In addition, "non-intact skin" includes skin with dermatitis, hangnails, cuts, abrasions, chafing, etc. Therefore, cases involving an "exposure incident" to an employee may be recordable while cases involving a splash to a person's "intact" skin are not recordable. These incidents must be recorded as an injury since OSHA has decided that the exposure was an instantaneous event.

The CPL 2-2.44C document identifies three types of bloodborne pathogens incidents that must be reported on the OSHA 200 log:

1. The incident is a work-related injury that involves loss of consciousness, transfer to another job, or restriction of work or motion.
2. The incident results in a recommendation of medical treatment other than first aid.
3. The incident results in a diagnosis of seroconversion of HIV. The serological status of the employee shall not be recorded in the OSHA 200. Seroconversions must be recorded as a "needlestick" rather than "seroconversion."

Employers have raised questions: Are all employees covered by the reporting requirements? What about employee privacy? A memorandum was issued by the OSHA division of record keeping requirements to all OSHA regional administrators in January 1994 to clear up these questions.

Employee coverage. The 1994 memo says that the bloodborne standard and the record keeping regulations are two separate rules and have different scopes of coverage. The bloodborne standard



applies to specific occupation. The injury and illness record keeping requirements cover all employees as defined in the OSH Act: "...one who is employed in the business of his employer" (see page 2 of the Recordkeeping Guidelines for Occupational Injuries and Illnesses). Cases meeting the criteria outlined on page 6 of CPL 2-2.44C must be recorded on the OSHA Log 200 whether the employee is covered by the bloodborne standard or not. For example, an employee who has been designated as a first responder would be covered by the bloodborne standard. An employee who gave first aid as a Good Samaritan would not be covered by the bloodborne standard but would have a recordable injury if hepatitis B vaccine were offered or recommended following an exposure incident.

Recommended treatment.

Under 29 CFR 1904, the term "medical treatment" includes treatment that is actually provided as well as treatment that is clearly required but not provided. Thus, recommended treatment need not be rendered to satisfy the recordability criteria. For example, if an employee refuses to accept vaccination for hepatitis B the incident is still recordable.

Examinations or other diagnostic procedures to determine whether an employee has an injury (HIV or HBV antibody testing for example) are not medical treatment. Counseling associated with occupational bloodborne exposures is also not considered medical treatment (though counseling for related mental stress may be considered medical treatment). Medical treatment involves the provision of

medical or surgical care for injuries through the application of procedures or systematic therapeutic measures. Generally, the draining of blood or bodily fluids is considered medical treatment for OSHA injury and illness record keeping purposes when performed as a treatment rather than as a diagnostic procedure. Taking blood simply for testing purposes is not considered medical treatment.

Privacy. Some employees have expressed concern that their HIV infection status would be available to other employees if seroconversion incidents are recorded. According to the January 1994 memo, all cases on the OSHA 200 Log must contain the injured or ill employee's name. Employers may not use coded personal identifiers on either the OSHA 200 or 101 documents. This may be changed in the 29 CFR 1904 revision proposal scheduled for next year. In practice, since seroconversions are to be recorded as "needlesticks" the seroconversion status of an employee is not available in the 200 Log, though it may be a matter for speculation by other employees.

Compliance impact: There are several important points. Employers should be familiar with the general OSHA recording standard. Exposure incidents must be recorded whether or not the employee is covered by the bloodborne pathogens standard. Incidents are recordable only if they involve exposure to blood through non-intact skin or mucous membranes.

Reprinted with permission from the *Bloodborne Pathogen Update* Volume 2, Number 3 May/June 1994. To order write to: David Hustvedt, Editor, Bloodborne Pathogen Update, 967 Poorman Road, Boulder, Colorado 80302.

New software aids OSHA training

Boulder based SciApp Corporation has rolled out a new CD-ROM based multimedia software package designed to train workers to meet the requirements of the Occupational Safety and Health Administration (OSHA)'s hazardous chemical regulations. Called SMILE™ HazCom, the program is adaptable to various training needs and schedules.

If your workers are already knowledgeable, they can merely take the 15 minute quiz and be certified. The program presents you with a detailed report of the results, including which areas need more work. If your workers need some refresher information, they can choose which modules to work through before taking the quiz. If they need the full training, four hours of information is available.

The multimedia format presents the information using animation, graphics, sound, text and interactive feedback. The basic information is presented at an eighth grade reading level, but is backed up by more than 900 voice files so reading is not necessary to successfully completing the training. SMILE™ HazCom uses an entertaining transportation theme to make the training pleasant. It also generates detailed reports of the training for your files and to prove to OSHA that the training requirements have been met.

SMILE™ HazCom is designed to run on an MPC system using Windows 3.1, DOS 5.0 or higher and Video for Windows. It needs at least



8MB of RAM (16 recommended), a VGA display, two button mouse, 1.44 MB 3.5" floppy drive, double speed CD-ROM drive, 170 MB of hard disk space and sound output capabilities (sound card with speakers or headphones). They recommend installing it off of the CD onto your hard drive for best performance. It's apparently not available for Macintosh. Price is \$2,000 for the unlimited use version, or \$300 for a copy limited to 300 uses. For more information, contact Mel Newville, SciApp Corporation, 8278 Songbird Circle, Ste B, Boulder, CO 80303, 303-442-0250.

Child Safety Posters Available

The National Highway Safety Administration is making available, free of charge, a poster which encourages the use of car safety seats for young children. The poster additionally provides information on the appropriate types of seats for infants, toddlers and pre-schoolers. To obtain posters, write to: Marian Fisher, Colorado Department of Transportation, 4201 East Arkansas Ave. Room 277, Denver, CO 80222, or call 303-757-9453.

Violence Prevention Resource Manual Available

The Violence Prevention Advisory Committee (VPAC), a 65-member multi-disciplinary, multi-cultural, statewide advisory group, in conjunction with the Injury and

Disability Prevention Program at the Colorado Department of Public Health and Environment, and the Center for the Study and Prevention of Violence in Boulder, has developed a violence prevention resource guide for the state of Colorado.

Violence in Colorado: Trends and Resources contains over 300 pages of information on violence-related issues. The manual includes an overview of violence and associated risk/resiliency factors; articles and fact sheets on specific types of violence (child abuse, domestic violence, homicide, suicide, rape, gang violence, and more); "tip" sheets on what individuals can do to reduce violence and protect themselves from violent situations; and strategies for community organizations. County-specific background information (population, median income, poverty, teen fertility rates, and alcohol/substance abuse arrests and treatment) and trends in reported violence (rates for homicide, assault, sexual assault, child abuse, and suicide from 1988 to 1993) are also included. Reference material includes county-specific resource and referral information.

Copies are \$10.00 each (includes shipping and handling.) To order a copy of *Violence in Colorado: Trends and Resources*, send a check or money order to the Colorado Department of Public Health & Environment, PPD-IP-A5, 4300 Cherry Creek Drive South, Denver, CO 80222-1530 or call 303-692-2592.

Ethical Dilemmas Individuals and Organizations: Navigating Healthcare Change

HealthONE will hold its third annual Ethics Conference Thursday, March 16, 8 A.M.- 3 P.M., at Pres/St. Lukes Medical Center. The program is designed for all healthcare professionals, particularly physicians, nurses and administrators.

The keynote speaker will be David Smith, Ph.D., Director, Poynter Center for the Study of Ethics and American Institutions. For information and registration, please contact the CME office of PSIMC at 869-2244.

Keep Up With Journals

Ask an assistant to photocopy the table of contents from every publication you receive. Then skim that for articles of interest. Circle their titles and have your assistant tear out or photocopy the articles. Not only does this save time, but you will quickly be able to compile a file of relevant articles to keep or distribute to your colleagues.

Source: *Career Tracking*

Dr. Folan honored

Richard Folan, MD, FACP, of Colorado Springs, Colo., a member of CMS for the past five years, has been elected a Fellow of the American College of Physicians (ACP), the professional organization of internists. Dr. Folan is a Gastroenterologist in private practice in Colorado Springs, CO.



Insurance Help for Seniors

Tired of paying someone to explain insurance benefits to your patients? Help is available. The Colorado Senior Health Insurance Assistance Program is a free counseling program for Medicare recipients and their families who wish assistance in understanding Medicare benefits and coverage gaps, medical bills, and other insurance options.

Specifically, the program's volunteers around the state help seniors organize, understand and process their medical bills; identify gaps in Medicare coverage and options to fill them; evaluate Medicare Supplement Insurance options; file Medicare appeals; understand their hospital and Medicare rights; and understand long term care financing options.

Services are provided through a statewide network of organizations who recruit volunteers, publicize services, and administer the programs. Counselors donate their time and expertise. All counselors attend extensive training programs and receive reference materials and referral sources for other information.

The volunteer counselors will not recommend or endorse specific insurance policies, but will educate and assist your patients in making informed choices. The program is operated through the Colorado Division of Insurance under a grant from the Health Care Financing Administration.

For more information, call Lori Conway at the Colorado Division of Insurance, 303-894-7499, ext. 356.

Participating Organizations

These organizations will help your Medicare patient find a local volunteer counselor. For information, you may also call the Colorado Division of Insurance at 303-894-7499, ext. 356.

Statewide—Provenant Medigap Hotline: 1-800-544-9181 (in Denver, 899-5151)

Arapahoe County—Interfaith Task Force: 789-0501

Boulder—Retired Senior Volunteer Program: 499-3307

Colorado Springs—Medical Insurance Assistance, Inc.: 632-1794

Cortez—AARP, Gen Hendrickson: 533-7185

Delta—Columbine Senior Services, Retired Senior Volunteer Program: 874-7661

Denver—Provenant Health Insurance Counseling for Seniors: 899-5151

Durango—San Juan Basin Area Agency on Aging: 259-1967

Fort Collins—Larimer County Retired Senior Volunteer Program: 482-8943

Fort Morgan—NE Colorado Association of Local Governments, Area Agency on Aging: 867-9409

Glenwood Springs—High Country Retired Senior Volunteer Program: 945-9117

Grand Junction—St. Mary's Senior Life Center: 244-2319

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Jefferson County—Retired Senior Volunteer Program/Seniors Resource Center: 238-8151

La Junta—Lower Arkansas Valley Area Agency on Aging: 3894-8166

Montrose—Columbine Senior Services, Retired Senior Volunteer Program: 249-9639

Pueblo—Parkview Episcopal Medical Center Volunteer Services: 584-4395 or 545-0178

Rifle—Area Agency on Aging (Garfield, Mesa, Moffat, Rio Blanco Counties): 625-1723 or 1-800-400-1723

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Stratton—East Central Council of Governments: 348-5562

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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

From the opening of a speech by Gary Trudeau, the "*Doonesbury*" cartoonist, at Yale University's Class Day:

"Dean Kagan, distinguished faculty, parents, friends, graduating seniors, Secret Service agents, class agents, people of class, people of color, colorful people, people of height, the vertically constrained, people of hair, the differently coiffed, the optically challenged, the temporarily sighted, the insightful, the out of sight, the out-of-towners, the Eurocentrics, the Afrocentrics, the Afrocentrics with Eurail-passes, the eccentrically inclined, the sexually disinclined, people of sex, sexy people, sexist pigs, animal companions, friends of the earth, friends of the boss, the temporarily employed, the differently employed, the differently optioned, people with options, people with stock options, the divestiturists, the deconstructionists, the home constructionists, the home boys, the homeless, the temporarily housed at home, and, God save us, the permanently housed at home."

Any more, I am increasingly cautious when speaking in public, for fear of offending someone by the simple act of not recognizing each of the special interests in a group.

Look around you, in the news stories, on your city or town streets, and start identifying the special interest groups by "entitlement". Identifying and acknowledging each of these groups is almost as mind-boggling as driving down that same street and counting up the number of messages being received and processed by your brain; in a single city block they're in the hundreds or more. If you just read every sign or label that is erected in that block by your city government, it can be a task. If you are looking for something specific as you drive by, think how much processing your brain is doing, receiving visual images, screening them for alphanumeric messages, rolling the rest through a sieve that says "*This is information I want and can use now; and this is not*", and then directing your body on how to use that information.

For instance: a simple thing like a changing traffic light. Your mind processes the picture into meaning: Orange says "*Caution! Be prepared to react*", but do you know which light will appear next? If it's to be green, then your body responds in one way. If it's red, that means a whole new paradigm. We react to the different colors by a process of distinguishing threat from promise: Red threatens dire consequences if we disregard this order, while green promises clear sailing. The body reacts to either circumstance, and principally based on entitlement.

Some years ago a psychologist said the number of messages we receive and process while driving one mile of city street is in the thousands. Not only are there directional signs and signals, there are individual signals, such as the way a home-owner decorates his house, landscapes his property, the kind of automobile he parks (or doesn't park) in front, whether the children are disciplined or free-thinkers in the way they leave their toys and belongings on the property.

The people themselves, each sending a message by how they appear in various activities, are a communications study all their own. Dress and personal carriage is always an indicator of personality and character. Each person's dress says something. Some dress and behavior says "*I demand*", or "*I am entitled*", while other traits say "*I don't care*" or "*I don't demand*". Some say "*Look at me and tell me what you think*", while others say "*I challenge you*".

I walk the city streets a lot, and I am fascinated by the study of people on the street, the message in their appearance, their attitude toward you. Some are saying "*leave me alone*", others say "*I am entitled: give me*", and others announce "This is my street". Of course there is the growing number of street denizens who are pretty nonplussed about everything.

Each proudly wears some label. None of these persons is without his or her entitlement. Just be very careful when you try to address one of them.

Or, do as Gary Trudeau did.

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Volume 92, Number 3



BROWN UNIVERSITY

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"Fields of Dreams"

Big projects on the Denver landscape; there are many parallels with medical practice. . . except that everything in health care seems to be running counter to the mainstream of public thought. See "RUMINATIONS" on page 116.

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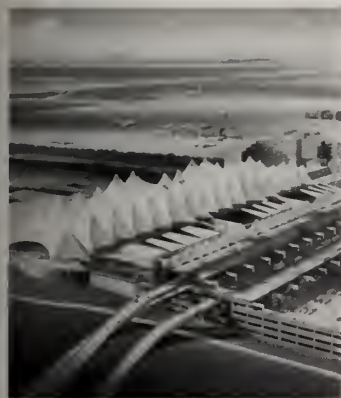
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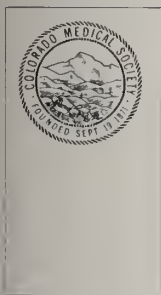
March, 1995

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Cover Story

"If you build it, they will come." Whether it's an HMO or a new airport, Denver's Fields of Dreams face unique obstacles. See page 116.



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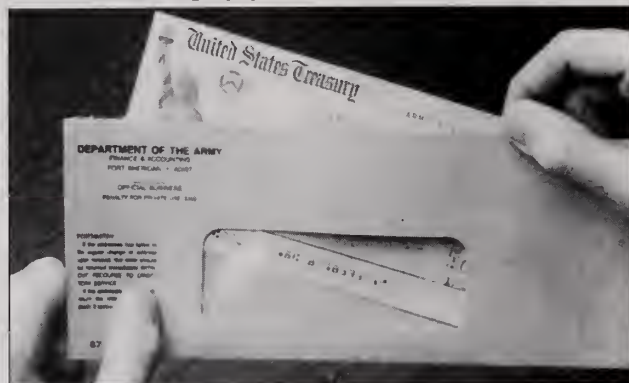
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CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax[®]

by **Montgomery Little and McGrew, P.C.**

legal counsel to the Colorado Medical Society

Medical Licenses Expire May 31

Renewal package in the mail

All licenses to practice medicine in Colorado expire May 31, 1995. **One Renewal Notice** will be sent to your designated mailing address approximately April 15, 1995. If you want your renewal sent to an address other than the designated address the Board has on file, please send or fax that change to the Board **ASAP**.

Colorado Board of Medical Examiners
1560 Broadway, Suite 1300
Denver CO 80202
Fax: 303-894-7692
Phone: 303-894-7690

After you receive your renewal packet, complete and sign all forms and use the envelope provided which goes directly to the depository. You will receive your 1995 pocket license within 4 to 6 weeks. *Do not send your renewal directly to the Board office.* Sending the renewal to the Board office will not expedite the renewal.

The Board has granted a two month grace period. That means your license will remain in active status until July 31, 1995. After August 1, 1995 until May 31, 1997, you can still renew by sending the renewal forms, fee and a \$25 late fee directly to the Board office.

If you have questions about the renewal, call the Board office at 303-894-7690.

Radiation Health Alert

Hanford Nuclear Weapons Facility in Washington State

The Hanford Health Information Network is seeking to contact people who lived downwind from the Hanford Nuclear Weapons Facility in Washington State during the years 1944-1972. During that time, 740,000 curies of radioactive iodine-131 were released to the air (as well as smaller amounts of other radioactive elements) and 22,000,000 curies of radioactive elements were released into the Columbia River. For comparison, Three Mile Island released 15-24 curies of I-131.

Many people who used to live in this region and may have been exposed are still not aware of this exposure and a large number have moved from the area. Therefore, it is possible that some of these people are your patients.

The exposure area includes most of Eastern

Washington, a corridor of Western Idaho and Northern Oregon from the Idaho border to the coast, including the Columbia River basin.

The primary health concern from this possible radiation exposure is thyroid disease. The Hanford Health Information Network has prepared information for health care professionals and patients about exposure. If you suspect one of your patients may have been involved in this exposure (you'll need a good medical history to find out) please contact the Network at 1-800-959-7660. The Network is a collaboration among the state health agencies in Idaho, Oregon and Washington in concert with nine Indian nations and was established by Congressional mandate in response to citizen pressure.



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate
with the law firm of Montgomery Little &
McGrew, PC.

*This column is not legal advice, but is
for general information only. For help with specific problems,
readers should consult an attorney.*

OBRA 1993 & Stark II

by Michael H. Smith, Montgomery Little & McGrew, PC
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The Colorado Lawyer. All rights reserved

The prevalence of financial relationships between physicians who have the power to refer patients for medical services and the entities that provide those services has long been a source of irritation to state and federal legislators. Over the years, a physician's freedom to enter into business arrangements involving such perceived conflicts of interest has been sharply limited. This article reviews the statutes enacted to bring about this limitation, including previous statutes and the Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993").¹

Background

At the federal level, a provision of the Social Security Act, commonly referred to as the Medicare/Medicaid Anti-Kickback Statute,² prohibits, among other things, any person or entity from giving or receiving any remuneration for the referral of services covered under Medicare or Medicaid. Approaching the issue from a different angle, Congress added § 1877 to the Social Security Act (42 U.S.C. § 1395nn) in 1989 to prohibit physicians from referring Medicare and Medicaid patients for clinical laboratory services if the physician has a financial relationship with the laboratory ("Stark I").

Most recently, under OBRA 1993, Congress amended § 1395nn to apply beyond the limited realm of clinical laboratory services to ten additional kinds of medical services ("Stark II").³ This newest weapon in the federal arsenal against improper healthcare referrals raises novel questions about many commonplace physician business arrangements.

By its terms, Stark II prohibits a physician from referring Medicare and Medicaid patients to an entity for the provision of "designated health services" if the physician (or his or her immediate family member) has a financial relationship with the entity, unless one of several narrow exceptions is met. In addition, Stark II prohibits payment for designated health services furnished pursuant to a prohibited referral.

Stark II essentially amends § 1395nn as it applies to clinical lab services, effective August 10, 1993. The extension of its prohibition to other designated health services takes effect on January 1, 1995. Thus, physicians and the newly expanded group of designated health service providers must act quickly to examine both existing and potential relationships for compliance with the legislation's terms.

General Observations

A few preliminary observations are useful to keep Stark II in perspective. First, the statute applies only to physician referrals for "designated health services" that would otherwise be covered by the Medicare or Medicaid programs. Referrals for non-Medicare or non-Medicaid patients and referrals made by someone other than a physician are not affected by Stark II.

Second, the prohibitions in Stark II exist in addition to and distinct from those contained under the Medicare/Medicaid Anti-Kickback Statute. The latter statute requires a showing of specific intent to violate the law. However, Stark II is a strict liability statute; the intent of the parties is irrelevant. Moreover, while the so-called "safe harbor provisions"⁴ promulgated under the Anti-Kickback Statute are, in some respects, similar to Stark II, they are not identical. Consequently, physician relationships must be analyzed for compliance with both statutes.

Finally, many aspects of Stark II require regulatory guidance, either under the specific terms of the statute or, as a practical matter, because of the breadth of the legislation. Until clarifying regulations are issued, a great deal of uncertainty will remain.

The Statutory Framework

In order for Stark II to apply, three elements (each specifically defined) must exist. First, there must be a referral, defined as any request by a physician for an item or service, including a request for consultation and any test or procedure ordered by or performed by or under the supervision of the consulting physician. In addition, a referral includes any request or establishment of a plan of care by a physician which includes the provision of designated health services. However, certain requests by a pathologist, radiologist or radiation oncologist for related services of not constitute referrals under the statute.

Second, the referral must be for one of the following eleven designated health services:

- 1) clinical laboratory services;
- 2) physical therapy services;
- 3) occupational therapy services;
- 4) radiology or other diagnostic services;
- 5) radiation therapy services;
- 6) durable medical equipment ("DME");
- 7) parenteral and enteral nutrients, equipment and supplies;
- 8) prosthetics, orthotics and prosthetic devices;
- 9) home health services;
- 10) outpatient prescription drugs; or inpatient and outpatient hospital services.

Third, there must be a financial relationship between the referring physician (or his or her immediate family member) and the recipient of the referral. A financial relationship exists when there is an ownership or investment interest in the entity (through equity, debt or other means, including an interest in the entity's parent) or a compensation arrangement with the entity. A compensation arrangement is any arrangement involving any remuneration between a physician (or his or her immediate family member) and an entity.

If all three elements exist, the referral may not be made and payment for services rendered pursuant to a prohibited referral may not be retained unless the arrangement falls within one of several statutory exceptions. The exceptions are divided into three categories: general exceptions that apply to both ownership and compensation arrangement prohibitions; exceptions that apply only to ownership and investment interests; and exceptions that apply only to compensation arrangements. It is largely in the application of these exceptions to specific factual scenarios that most of the questions concerning the interpretation of the statute will arise.

General Exceptions

Physician Services

Under what has come to be referred to as the "group practice exception," Stark II does not prohibit a referral for physician services that are provided personally or under the personal supervision of another physician in the same group practice as the referring physician. Not surprisingly, the statute contains a lengthy and detailed definition of the term "group practice." For purposes of this article, suffice it to say that a group practice requires at least two physicians legally organized in an associational form such as a partnership, professional corporation or foundation.

The group members must essentially conduct their practices through the group, bill in the name of the group, and share overhead and revenues of the group. Group members may not, directly or indirectly, receive compensation based on the volume or value of referrals, although physicians may be paid a share of overall profits of the group or a productivity bonus as long as the share or bonus is not based on the volume or value of referrals by such physician. In addition, members of the group must personally conduct no less than 75 percent of the physician-patient encounters of the group practice. Finally, the statute authorizes the Secretary of Health and Human Services ("HHS") to impose additional requirements by regulation.

The group practice exception is curious in that it applies to referrals for "physician services", notwithstanding that such services are not listed among the designated health services included under Stark II. That issue aside, it appears that Stark II permits physician referrals for designated health services within a "clinic without walls," assuming the shared overhead and income criteria, among the other criteria, are satisfied. The exception may be applied even if the individual office sites have as few as one physician - a departure from earlier versions of the bill, which would have required five or more physicians at each site.

Next Month: More Exceptions to OBRA '93 and Stark II

CMS-ERF Awards \$5,000 Scholarship

The Colorado Medical Society is pleased to announce Shawna Rae Harris as the recipient of the 1995 Education and Research Foundation Scholarship.

The award, in the sum of \$5,000 is presented annually to first and second year students from rural Colorado. Candidates must have high academic credentials as well as financial need.

Shawna is currently entering her second year at CU Medical School. She completed her undergraduate work at the University of Denver receiving a B.A. in Biology and English. She has received numerous citations for Academic excellence.

When Shawna is not studying, she volunteers her services with the Stout Street Clinic and is a member of the Medial Student Component of The Colorado Medical Society Executive Committee.

Copic Acquires Credentialing Service

Copic is pleased to announce the acquisition of Gadrian Corporation, a provider credentialing company.

"Copic saw Gadrian as a natural enhancement of our existing services to our physician insureds," said Jerome M. Buckley, M.D., Copic's new CEO, and longtime Board member.

Copic has been a primary source for credential information verification by hospitals, managed care organizations, and others for some time. Gadrian was viewed by the Copic Board as an opportunity to reduce the administrative burden placed on physicians by minimizing or potentially eliminating the collection of redundant information associated with multiple credentialing efforts.

Credentialing has become an increasingly critical managed care function. Independent verification of physician credentials, a part of quality assurance, is included in managed care accreditation requirements of the National Committee for Quality Assurance (NCQA). Therefore, a physician must be credentialed each time she/he joins a managed care entity.

The intent of this credentialing service is to collect primary source documentation on a physician's credentials once and then provide it to various organizations.

The automated nature of Gadrian Corporation's credentialing process allows the entities to meet the required accreditation standards every two years.

The Copic Board and management are committed to finding ways to permit physician insureds to practice medicine in an environment that respects their time and personal commitment to their patients. Solving the credentialing dilemma with this investment is another step in meeting that commitment. Copic is also working through the Colorado Medical Society and other organizations in the development of a standardized application.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Advisory Council on Health Programs for Women and Children

Regular monthly meeting.

For information call Suzette Clark at (303) 692-2421.

Colorado Department of Public Health and Environment

Colorado Board of Health- Public Rule-Making Hearings:

March 15, 1995

9:00 a.m., Board Room A First floor, Building A

Meetings are held at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver.

Colorado Department of Public Health and Environment

Advisory Council of Adolescent Health

March 17, 1995

Meetings are held at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver.

Medical Records Institute

"Toward an Electronic Patient Record '95: Eleventh International Symposium on the Creation of Electronic Health Record Systems and Global Conference on Patient Cards.

March 14-19th, Orlando, Florida

Contact: Leslie Campbell- (617) 964-3923

Rose Institute for Joint Replacement

"Treatment Options for Arthritis"

March 15, 1995

Aurora Senior Center, 30 Del Mar Circle (near 6th and Peoria).

Contact: 320-7673. (Seating is Limited)

Rocky Mountain Regional Pre Hospital Services

March 14-16, 1995

BTLS Provider Course

Littleton Hospital

March 28th & 30th, 1995

ACLS Provider Course

Littleton Hospital

Contact: (303) 733-3967

Colorado Organ Recovery Systems

Pieces Of The Puzzle: "Meeting the Challenge of Organ and Tissue Donation"

March 24, 1995

Crystal Rose- Golden, CO.

Contact: CORS, (303) 321-0060

Presbyterian/St. Luke's Medical Center

New Developments in Cancer Biotherapy: the 2nd Decade

March 30-April 2, 1995

Beaver Run Resort, Breckenridge, Colorado

Contact: Mary Fletcher, 303-869-2244

HealthONE

Geriatric and Surgical Urogynecology

March 31-April 2, 1995

Beaver Run Resort, Breckenridge, Colorado

Contact: Mary Fletcher, 303-869-2244

Medical Group Management Association

Spring Meeting- "Mid-Level Providers: Extending Services, Expanding Revenue, Avoiding Pitfalls

April 20, 1995

Denver, CO.

The Inverness Hotel (Formerly The Scanticon)

Contact: (303) 397-7881

The 8th Annual Penrose-St. Francis Trauma Symposium

"Trauma, the 20th Century Epidemic: Continuity and Communication"

April 28, 1995

Colorado Springs, CO.- Red Lion Hotel

Contact: (719) 776-5926



PRESIDENT'S LETTER



David C. Martz, MD
President, 1994-1995

As I prepare this letter for you in mid-February regarding the Interim Meeting in mid-March, it is with the recognition that by the time you receive this the information contained herein may be history rather than news. However, as such, uncertainties are fractional factors of the mathematics of medical management, I will take that risk!

Those of you who have followed our activities since the Annual Meeting in September may be well aware of our intent to be **innovative** in CMS leadership this year. Our efforts have run from such trivial issues as revising the Board of Directors agenda and seating arrangements to the far more complex issues of coalition-building within the house of medicine and other health care providers, a White Paper with the HMO Association (which is the first of its kind in the nation to negotiate affiliation-disaffiliation issues), a PROactive rather than REactive legislative approach (including our own "Point of Service" bill), and a \$140 thousand feasibility analysis of a potential statewide physician-friendly managed care organization (Colorado Physician's Network, Inc.).

The 1995 Interim Meeting of the House of Delegates will be no exception to their innovative approach!

The Annual Meeting held in September is typically dominated by dozens of resolutions. Last September we dealt with no less than 44. It is a three-day event for Delegates (4 days for Board members) which includes officer elections, presidential inauguration, and extended

debate in reference committees and on the floor of the House pertaining to policy development, actions of the Board, and resolutions submitted from many sources.

Conversely, the Interim Meeting is brief in duration and content, lasting only a day and a half and usually dealing with more limited issues. There has been periodic discussion within Colorado Medical Society as to the advisability of permanently canceling the Interim Meeting, but this has been regularly defeated by the vote of the House of Delegates who consistently express the importance of at least semi-annual congregating to maintain a more "hands-on" leadership responsibility than would be possible with only annualized meetings. The value of ongoing networking with both leadership and delegates throughout the state is a recognized additional benefit. The possibility of linking the Interim Meeting with an educational program or leadership conference has also been previously discussed.

This year, only seven relatively noncontroversial resolutions have been submitted which -- barring soapbox logorrhea or a plethora of constipating late-resolutions -- would allow us ample time to pursue alternative approaches this year.

The Speaker of the House and your Executive Committee have decided to take the risk of offering you a modified during the Sunday morning session of the House of Delegates that will provide a forum to review the "state of the Society" with input from both leadership and membership.

"State of the Society" forum at '95 Interim Meeting

Presuming (?) that we can deal with the business of the House by 9:30 a.m. on Sunday, a two-hour State of the Society forum from 9:30 to 11:30 a.m. has been planned. This will include an overview by Council Chair Dick Allen of the legislative issues facing physicians in 1995, where CMS stands on these issues and what is being done to change, amend or invalidate the proposed legislation; a report by president-elect Joel M. Karlin on "My Doctor. My Choice"; a report by Council Chair Bob McCartney on Affiliation/Disaffiliation--HMO Association White Paper; an update on the **Colorado Physician Network** by the new consultant, David Ginsberg and me.

A brief presentation followed by ample time for open discussion is intended. It is our hope that this will result in multidirectional education, enlightenment, and input regarding key issues of our society's activities this year. We are insisting that the presenters be succinct, and would hope that respondents would reflect similar restraints so that many can be heard.

(Continued on following page)

The theme of the meeting is "Integrated Delivery Systems" (IDS). This extremely complex and timely topic is being featured at the urging of the Health Affairs Council in general, and its Chairman, Dr. Robert McCartney, in particular. Mr. Dean Coddington, nationally recognized author and spokesperson on IDS, will be the keynote speaker. The luncheon which follows the Keynote Address on Saturday will include a panel discussion of several elements of IDS, including a Physician Organization (Dr. Mark Levine), a Physician Hospital Organization, an Insurance

Physician Organization (Dr. Pat Rooney), and, if possible, a large single specialty organization.

We recognize that this issue is of such magnitude and ongoing change that these presentations may constitute more of an introduction to the issues rather than definitive solutions. The Health Affairs Council is already outlining methods of continued dialogue for the months ahead.

Should you read this BEFORE the Interim Meeting, I sincerely hope that these innovative efforts will be beneficial to all. Alternatively, if you read this AFTER March 12, I pray

that the results WERE to some degree successful!

In any case, we shall continue to live by the precept, "*nothing ventured, nothing gained*" with the belief that if things COULD be better we must risk helping them change! Don't forget, if you want to be part of that process personally, you can call "**Tell Dave**" at (303) 930-0420 and leave your "two-fisted comment" - the issue in one hand and the potential solution in the other.

Looking forward to hearing from you.

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000

Communicating with Insurance Companies

Why do some doctors have little trouble getting their bills paid while others are always audited and their patients sent for Compulsory Medical Examinations? Communication is the key!

You have 30 days from a patient's initial visit to provide information to a carrier. If you don't, neither the carrier nor the patient is obligated to pay the bills. We recommend, however, that your bills be sent to a carrier within 14 days after a patient's initial visit. Be sure to furnish:

- Itemized bills
- Clear and legible records, including detailed history, results of the physical examination, subjective symptoms and objective results of tests, and your diagnosis
- Results of any radiologic films
- Detailed treatment plans
- Advice to the adjuster about your causal opinion
- Your best opinion concerning a prognosis

Much of the above information can be forwarded to the adjuster with your records in the form of a report. Communicate early and often the basis of your opinions regarding the need for treatment, as well as your diagnosis and prognosis. The longer you take in providing this information in a clear and concise

manner, the more problems you will likely have with the adjuster. Adjustors communicate with each other and share information about specific doctors. If you fail to provide up-to-date information, you will soon have a problem with the carrier, not just one adjuster.

This process takes time but, in the long run, will save a tremendous amount of time and alleviate some of the aggravations of dealing with a carrier that refuses to pay your bills. It will also give you a better opportunity to help your patient obtain treatment with less interruption in care, thereby improving full-recovery chances. At the very least, you will build a complete record for any compulsory examiner to review, or for a judge or jury to later base a decision or judgment upon.

Clear, concise and easy-to-follow records provided to a carrier as soon as possible after beginning care of a patient indicate that quality care is being provided by a quality health care provider. For further information, please contact:

A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling, P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society



What an incredibly busy time of year. There is so much going on that it is difficult to determine where to start. CMS is involved with and tracking so many issues that it is very hard to choose. Which ones are the most important? It depends on your specialty, your age group, geographic location of practice, and your overall point of view. Because CMS represents all physicians in Colorado, regardless of the categories mentioned above, the issues all become priority items for your staff.

Perhaps information on the Nurse Practice Act would be helpful to you. Clearly, it has been identified as a priority item. Let's see.... no, can't say that. Hmm. Gosh, this is going to be harder than I thought. It is difficult to write about a sensitive issue when, undoubtedly, some group or individual is going to be unhappy with my remarks. (Remember, our readership goes far beyond the membership of CMS.)

Maybe information on the legislative proposal that would allow all Colorado hospitals to directly employ physicians would be helpful. Let's see.....no, can't say that. Hmm. This is even *more* difficult than I thought. Again, with such a sensitive issue, it is likely that I will make someone unhappy with my remarks.

Perhaps I should speak about participation in "coalitions". I must admit there are times when working in coalitions can be more of a problem than they are worth. Yes, attempting to gain consensus is important however, it is also important to recognize that there are times when the parties involved in coalition activities simply must agree to

disagree. Again, can't afford to step on anyone's toes so, it's best that I not pursue this issue.

Then there's the Death With Dignity Bill (physician assisted suicide). Now there's a hot topic! Well, it is probably not a timely topic anyway — the bill died (with dignity) in committee.

As you can plainly see, there are a multitude of issues that we deal with daily on which there are several points of view. It is apparent that we can't make everyone happy. As CMS staff, our first responsibility is to carry out the policies set by the Board and the House of Delegates. These policies are not always popular with the entire CMS membership, the legislature, state agencies, and others. I was accused the other day of appeasing CMS membership at the expense of another. It's true. I took this statement as a compliment. CMS policies are not set without careful thought and consideration regarding the impact of such policies on physicians and patients. It's too bad that the folks on the "outside" don't understand this.

We were also accused of negotiating in bad faith. I'll not go into the gory details, suffice to say that I mentioned the bill earlier in this article. Anyway, this issue came down to established CMS policy versus what the "outsiders" wanted. CMS must hold firm to established policy. If the policy is outdated, then we need to modify, but in the meantime we deal with what we have. If any of you don't like a particular policy, submit a resolution to change it at the next House of Delegate's Meeting.

"Damn those chickens!!"

Hmm.... Wonder if that comment will offend anyone.

There I go again. If you read my last article, you will remember that I wrote about chickens. Well, I have another feather to pick with these stupid creatures. It seems that from chickens come eggs. From eggs come egg shells. That's what I feel that CMS staff walks on a good portion of the time. Damn those chickens!!



THE LOBBY



Richard Allen, MD
Chairman, CMS Council on Legislation

"Are citizens ready to take responsibility for their personal behavior, particularly unhealthy behavior. . . ?"

The activity at the Capitol is now fast and furious. I held off writing this article until the last minute since events literally change daily. The deadline for this article was February 15 and I asked for one day extension as I wanted to wait for the results of the House HEWI Committee action on HB 1262, the CMS Point of Service bill. In addition, the State's Health Care Policy office convened a special meeting with Governor Romer and selected invitees that same afternoon to discuss in what direction, if any, state government should go regarding health care reform. Those attending were primarily hospital and managed care group CEOs and various business interests. There were some physician representatives from the medical school while Joel Karlin and I represented CMS. There was considerable support, especially from business, to give the reform bills passed last year a chance to work, but most felt there needed to be an ongoing evaluation of where we were and where we wanted to go. It was felt that we particularly needed to look at health outcomes since services delivered and dollars paid out did not always translate into better outcomes. Some of the questions raised by the Governor were:

- Did the state need to get involved with what's happening now, and is what's happening now (i.e. Columbia coming in and buying Rose) okay?
- Should we continue to expand facilities, specifically the Health Sciences Center, and are the various legislative bills, such as

Any Willing Provider, reasonable, or does he have to exercise his veto?

- What should the state be telling the federal government, and do we want block grants from Medicaid?
- Are citizens ready to take responsibility for their personal behavior, particularly unhealthy behavior, and what role, if any, does the State need to play?

As you can see, there was plenty of discussion material and it remains to be seen where we go from here.

Meanwhile, back at the House HEWI Committee, our bill for requiring employers to offer a point of service option was receiving its hearing. Dr. Karlin made an eloquent presentation and Dr. Bob Sawyer related some relevant and sympathetic anecdotes. Dr. Martz and I were there, along with the CMS Executive Director Sandi Maloney and the government relations and lobbying staff. When the bill's sponsor, Rep. Martha Kreutz, and CMS finished our presentations, our opponents took their shots at us.

Speaking against the bill were virtually the entire insurance industry and the HMO Association (puzzling, since they practically all offer a point of service option now), business as represented by the NFIB (National Federation of Independent Business), CACI (Colorado Association of Commerce and Industry), and the Colorado Hospital Association (also puzzling since, if anything, it could increase hospital business by allowing patients to go out of plan to another hospital). In any event, our arguments prevailed and the bill

passed out of Committee by a 9 to 2 vote. Our opponents confidently looked forward to killing the bill in Appropriations. Thus, the battle continues.

CMS Key Contacts were sent two "ALERT" letters mid-February which I hope you have all read and responded to. One was on our Point of Service bill, HB 1262, and the other was on SB 162 which would remove all the qualifications (particularly the requirement for a medical degree) from the State Health Director position. CMS is opposed to this and we feel that the Health Department should be run by an MD and that there are qualified MDs out there who also have administrative credentials and expertise. The latter is the sticking point, as the Gover-

nor's office doesn't believe this. The bill was sponsored by Senator Tom Norton, who has an engineering background. He feels that environmental issues are best administered by someone other than an MD. The Senate HEWI Committee had serious reservations about this and the end result was that Senator Norton removed the bill from consideration so that he could rework it. Thus, from a lobbying standpoint, we've had a good week, but we are still a long way from resting on our laurels. All of these issues will be back.

Finally, thanks to those of you who have taken an interest and given me feedback for the Council on Legislation. I have had the pleasure of addressing several county medical societies and I appreciate the

comments of those attending (yes, even those who blame me personally for the intrusion of managed care, etc., on their lives). We need everyone's support.

Here's the point that I would like to leave you with: It is extremely important, in fact critical, that we have your support. When you receive a letter from CMS with the word "**ALERT**" in red letters, please read it and take action. Legislators respond to the **volume** of calls and letters they receive concerning an issue. Thus, we need **everyone** to respond. Do not rely on someone else to do the responding for you. The time and effort required is minimal and the importance of a personal response is great.



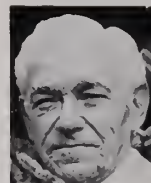
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The IME PIP Controversy



by Frederick A. Lewis, Jr., MD

"CMS would be glad to help...to devise a workable solution which... provides the proper treatment for all patients ... "

In June, 1995, the Colorado Insurance Commissioner (Jack Enhes) organized a Task Force to study the changes to PIP Automobile Insurance which had been suggested in a ballot initiative which surfaced about that time. The group consists of representatives from the insurance industry, consumers, the plaintiffs' bar, and providers. I was appointed to represent the Colorado Medical Society. In addition to other issues, we have been discussing Independent Medical Examinations, off and on, for six months and it did not appear that we were making a great deal of progress.

The Chiropractic Association and the Hospital Association have both proposed different lists of restrictive regulations. In that context, I made an effort to re-frame the debate in a constructive manner and asked each of the groups to accept the following assumptions as a starting point for constructive dialogue. It is too early to know whether or not this effort will be successful, but it seemed appropriate to report my reflections to the membership at large. This is being done in the hope of stimulating dialogue and if you have different views, please let Colorado Medicine know.

I suggested that the group accept the following assumptions:

1. The entire health care delivery system is in the process of undergoing fundamental changes. This process is economically threatening to many health care providers and could serve as an inducement to providing unnecessary care.
2. The PIP Medical Delivery System is one of the last bastions of "fee for service" medicine. There are very few rules or regulations which limit the benefit structure and ongoing health care can continue for years. This tends to drive up the damages available through litigation and, thus, potentially benefits both patients and plaintiff attorneys. Health care providers benefit through increased reimbursement. When this occurs, insurance companies are penalized because of their increased expenditures for unnecessary medical services.
3. In general, the PIP delivery system does not appear to be a problem for patients who suffer significant, verifiable, physical injuries in MVAs.
4. Problems seem to occur, primarily, in patients with continuing subjective complaints and no significant objective findings on physical, laboratory, or radiographic examination. Unfortunately, (or fortunately) this compromises the majority of patients injured in MVAs.
5. Insurance companies have adopted, almost universally, the IME system in an effort to curtail the amount of unnecessary medical care. Whether you believe the incidence is 2% or 20%, the problem of unnecessary care should be acknowledged.
6. Insurance companies currently use IME physicians as agents to help control the amount of money expended for unnecessary medical care. Any successful effort to weaken the effectiveness of this system will result in higher insurance costs, higher automobile in-

The IME PIP Controversy

(Continued)

- insurance premiums, and will ultimately be detrimental to the average consumer.
7. The current system works quite well when the IME doctor is fair, objective, and impartial. It results in continuing care for patients who need it and denies care to patients who cannot benefit. To assume that the treating physician is impartial or unbiased is naive. He is (and should be) biased in favor of the patient.
 8. When IME doctors are not objective and impartial, or render favorable opinions for the insurance company in unwarranted circumstances, this creates an equally serious problem which is quite detrimental to patients. Again, this is a very real problem whether the incidence is 2% or 20%. My perception is that the Task Force has been trying to address this problem in our meetings.
 9. We currently have a delicately balanced system which attempts to protect against unnecessary medical care while, at the same time, insuring that patients who need care get it. No hard data has been submitted to the Task Force which suggests that the current system is fatally flawed. Undoubtedly there are problems. However we will not be performing a service by either ignoring the problems or unduly restricting the current system.
 10. To CMS, the solutions do not lie in the creation of a series of restrictive rules and regulations, which will hamper conscientious doctors from doing their job - whether this is helping patients or stemming the flow of premium dollars for unnecessary medical care.
 11. If one accepts these assumptions, the problem becomes one of providing a structure which will insure that all IME physicians are conscientious, fair, and impartial - recognizing that, at times, there may be legitimate medical differences of opinion. This goal is obviously an idealistic one but it certainly can not be achieved by legislation or regulation. One alternative would be to adopt an ADR system for the "singular case" in which the patient and/or his attorney is convinced that the IME doctor is biased, unfair, or not impartial.
 12. There are probably a number of different possibilities.

One would involve setting up an appropriate (appropriate to the individual case) panel of doctors (? three) who would serve as a kind of appellate court. The cost should be borne by the losing party. There are undoubtedly many other possibilities. CMS would be glad to help provide the leadership in attempting to devise a workable solution which will attempt to insure that we have an equitable system which provides the proper treatment for all patients who need it and, at the same time, curtails unnecessary medical care.

The New Food Label

Check It Out!

Nutrition Facts

Serving Size ½ cup (114g)

Servings Per Container 4

Amount Per Serving

Calories 100 **Calories from Fat** 30

% Daily Value*

Total Fat 3g **5%**

Saturated Fat 0g **0%**

Cholesterol 30mg **10%**

Sodium 660mg **28%**

Total Carbohydrate 13g **4%**

Dietary Fiber 3g **12%**

Sugars 5g

Protein 5g

Vitamin A 4% • Vitamin C 2%

Calcium 15% • Iron 4%

*Percent Daily Values are based on a 2,000 calorie diet.

Have you seen the new food label? It's appearing in grocery stores everywhere! The new food label makes it easier to find out what's in the food you eat. It helps you compare products quickly. Look for the box called "Nutrition Facts" on the side or back of the package—that's how you know it's the new food label.

A public service of this publication and the U.S. Food and Drug Administration.

A ntioxidant research growing in importance



CMS member Henry W. Toll, Jr., MD peers through a newly funded microscope as part of his research activities at the Webb-Waring Institute.

Researchers at the Webb-Waring Institute for Biomedical Research in Denver are finding links between the imbalance of antioxidants and oxygen radicals and devastating diseases such as cancer, AIDS, Alzheimer's Disease, as well as common heart and lung diseases. In fact, the Institute has recently patented a diagnostic blood test that may determine predisposition to Acute Respiratory Distress Syndrome (ARDS), a lung disease claiming more than 150,000 lives annually. ARDS is caused by an imbalance of too many oxygen radicals creating fluid in the lungs.

Scientific evidence from Webb-Waring, a leading international center in antioxidant research, supports the concept that there is an ideal balance in the human body between oxygen radicals (toxic forms of oxygen) and antioxidants (the

body's natural defense against oxygen radicals). Scientists there predict that identifying the level of antioxidants may someday become as important to predicting diseases as cholesterol screening is today.

Many diseases are caused by excess generation of oxygen radicals, which come from many sources within and outside the body. Oxygen radicals can damage crucial cellular molecules, lipids, proteins and DNA.

Scientists at Webb-Waring have also looked into how oxygen radicals kill immune cells in AIDS patients. Laboratory tests show that controlling oxygen radicals and restoring this balance may prevent damage to the immune system, and keep patients from developing AIDS.

"Finding the exact balance between antioxidants and oxidants, and investigating methods to treat an



After more than seventy years, Webb-Waring is still on the cutting edge.

imbalance, may prevent many diseases and could revolutionize the way we practice medicine," says John E. Repine, MD, president and director of Webb-Waring.

In addition to developing antioxidant tests, Webb Waring scientists are researching the use of antioxidant therapies as treatment to control oxygen radicals, and determining why some people naturally produce fewer antioxidants. These therapies are more than just taking antioxidant vitamin supplements. Researchers are also designing strategies to trigger the body to produce more antioxidant compounds, which are crucial to maintain health.

"Many of today's diseases that seem unrelated have a common denominator," says Joe McCord, PhD, director of Webb-Waring's biochemistry division. Dr. McCord, who worked on the team who first discovered the implications of antioxidants and oxygen radicals, says that maintaining health may begin with the proper level of antioxidants and oxygen radicals. "But when this balance tilts towards more oxygen radicals and not enough antioxidants to counteract, our immune systems weaken and disease ensues," McCord adds.

The Webb-Waring Institute for Biomedical Research, located in Denver, Colorado, is a private, not-for-profit research center dedicated to biomedical research and education since 1924. Widely recognized as a leading international center for oxygen radical and antioxidant research, Webb-Waring scientists

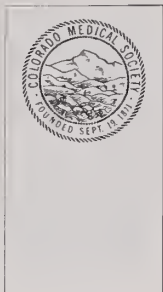
were among the first to study the role of antioxidants, and ways to use antioxidants to prevent disease and maintain health.

Researchers at Webb-Waring are also studying Amyotrophic Lateral Sclerosis (Lou Gherig's Disease), AIDS, Pulmonary Oxygen Toxicity, Heart Attack, Stroke, and Tuberculosis. Dr. Repine says "In this past year, our investigators have made dramatic scientific progress, particularly in the areas of AIDS, Lou Gherig's disease, cancer and the Adult Respiratory Distress Syndrome. ...I am confident that our 'radical' approach to biomedical research will yield important medical breakthroughs in the near future."

Webb-Waring also has extensive educational programs for high school, college, medical and graduate-school students. These young scientists are provided with a hands-on learning experience and are immersed in actual research experiments at Webb-Waring. For more information, call Webb-Waring at 303-270-8231.



Antioxidant tests could become as common as cholesterol screening



BOARD HIGHLIGHTS

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - January 13, 1995

- Copic:** Dr. Buckley reported that he and Dr. Martz have met and have scheduled additional meetings to discuss matters of mutual interest.
- CMSA:** Ms. Patti Brown, President, asked for the Board to approve her appointment to the Hall of Life Advisory Council. The Board approved her request.
- AMA Delegation:** Dr. Quinn reported that Dr. Richard Allen is a candidate for election to the AMA Council Medical Service, Dr. Eugene Jacobson is a candidate for the AMA Council on Scientific Affairs and that Dr. Quinn is a candidate for the AMA Council on Constitution & Bylaws. Dr. Karlin is seeking appointment to the Council on Legislation.
- Board of Directors:** The Board approved the agreement between the Colorado HMO Association and the CMS regarding the affiliation and disaffiliation of physicians.
The Board approved a motion to support the concept that an adequately trained, adequately qualified physician be appointed head of the Colorado Department of Health and Environment.
The Board approved the Workers' Compensation Advisory Committee request to change the name of the committee and the charge of the committee to include issues of personal injury such as auto no-fault, etc.
The Board approved a motion for Dr. Martz to appoint volunteer members to the transitional board for the physician network organization and to proceed with an organizational meeting.
The Board approved the My Doctor/My Choice campaign with funding on a voluntary basis by physicians.
The Board approved the formation of a CMS Patient Committee with the intent of forming an alliance with the patient population.

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - February 10, 1995

- Copic:** Dr. Buckley reported that Copic has entered the credentialing arena and is working with CMS to develop a universal form to be used by physicians to submit to all entities.
- CMSA:** Ms. Patti Brown, President, announced that Legislative Day had been very successful.
- Board of Directors:** The Board approved a position statement on Expert Witness, submitted by the Workers' Compensation & Personal Injury Cmte, which identified appropriate information versus the inappropriate information which may be requested by attorneys.
The Board approved CMS involvement with a Provider Coalition with the clear understanding that differences will arise and that CMS will not be listed as a member when CMS individually is in opposition to a particular piece of legislation.
The Board approved a monies advance to purchase supplies and copyright permission to begin the "My Doctor, My Choice" campaign.
- Executive Director:** Ms. Maloney reported that CMS memberships had reached an all time high of 5000 plus.

RAM

Recent Affiliations and Mergers (in Colorado)

*Prepared by the Colorado Medical Society Health Care Financing Department
Edie Register, Director
Marijo M. Parkin, Program Manager*

Key: DP = Denver Post; CMC = Colorado Managed Care Newsletter; RMN = Rocky Mountain News; DBJ = Denver Business Journal; C/M = Colorado Medicine

- The January issue of RAM reported that Health Systems International, which merged with Pueblo-based Qual-Med earlier this year, received buyout offers from two rival California health maintenance organizations, Foundation Health Corp. and FHP International Corp.

Both offers were later withdrawn in early January. (CMC 1/23/95)

- The January issue of RAM reported that Provenant Health Partners and Rocky Mountain Adventist Healthcare Corp. had entered into negotiations to form an alliance that could become the powerful core of a health-care system covering the north, west, central, and southern parts of the metro area, experts suggested.

The two hospital groups have now signed a letter of intent to explore a closer relationship (CMC 1/23/95)

Columbia/HCA Update

Columbia/HCA is conducting discussions in Colorado Springs with Memorial Hospital. The hospital has been city-owned since 1943. Any proposal to sell the 275-bed hospital will be subject to a vote of Colorado Springs residents. (DP 1/21/95)

Rose Health Care System has approved a sale to Columbia/HCA Healthcare Corp., the nation's largest for-profit hospital company. Although terms of the Rose-Columbia agreement were not disclose, its price tag is rumored to be well over \$125 million. (DP 1/18/95)

Columbia/HCA is still in discussions with HealthONE System.

Children's Hospital and Columbia/HCA are currently exploring a relationship. No letter of intent has yet been signed, but Columbia is reviewing Children's financials. (CMC 1/30/95)

- Sloans Lake's new HMO, which has been named Sloans Lake Health Plan, will be applying for regulatory approval from the Colorado Division of Insurance within the next couple of weeks. (DBJ 2/2/95)

- An agreement creating a formal affiliation between University Hospital, the University of Colorado School of Medicine, The Children's Hospital and the National Jewish Center for Immunology and Respiratory Medicine should be signed next month.

The agreement would send inpatients from National Jewish to either University or Children's, and those hospitals would refer some of their outpatients to National Jewish.

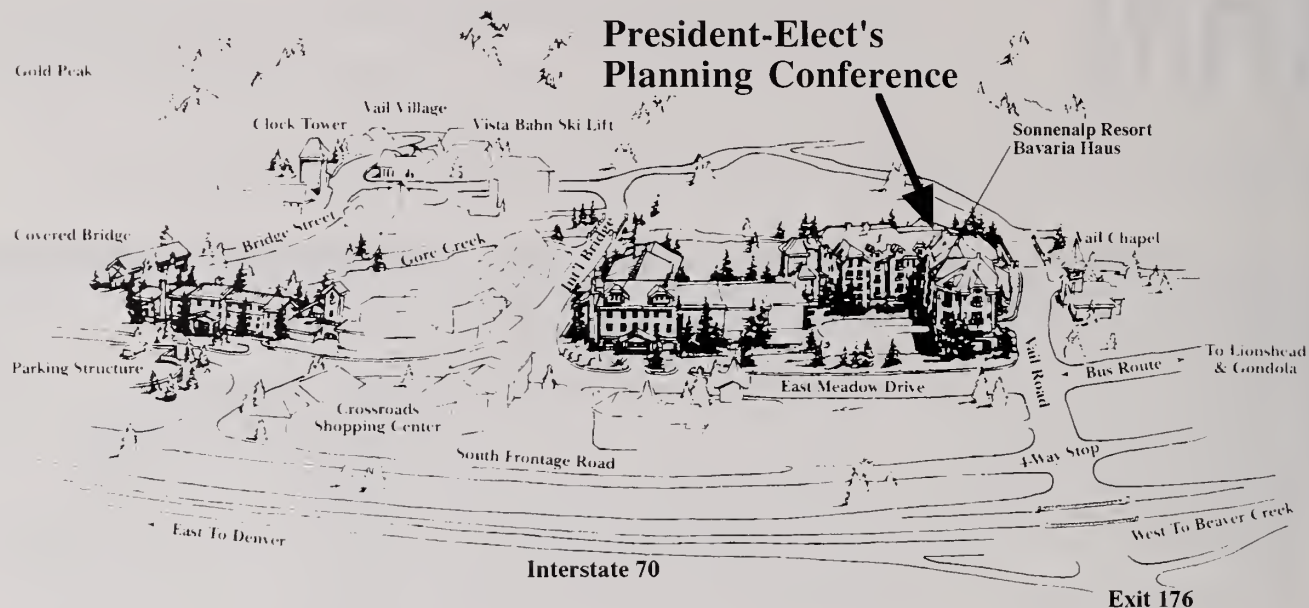
University also is negotiating affiliation agreements with other hospitals separately, including Children's and Denver General Hospital. (DBJ 2/2/95)

- The Colorado Springs Medical Center has now become Colorado Springs Health Partners. It continues as a multi-specialty physician group serving Colorado Springs, and it has now become FHP's provider group in Colorado Springs. It contracts directly with FHP, separate from Columbine Medical Group. (CMC 1/23/95)

Recent Affiliations (or acquisitions) and Mergers in Colorado.

Some of them are being "rammed" through with such speed the number and monthly growth are astounding. (This report represents just one month of activity that has been made public. It's not known how many other deals have been cut but are still under wraps.)

How to get to the CMS Leadership Conference



Daniel "Stormy" Johnson, Jr., MD to keynote Leadership Conference



Daniel Johnson, Jr., MD

Daniel Johnson, Jr., MD, a diagnostic radiologist from Metairie, Louisiana, was reelected speaker of the American Medical Association (AMA) House of Delegates in June 1994. Prior to becoming speaker in 1991, Dr. Johnson had been vice speaker since 1987. He has served as a delegate since 1983 and as an

alternate delegate from 1980 to 1982.

Long active in organized medicine, Dr. Johnson chaired the Louisiana State Medical Society's (LSMS) committees on long-range planning, advertising and fee complaints, and alternative delivery systems. He was speaker and vice speaker for the LSMS House of Delegates for eleven years and is a past president of the society. He is a member of the board of the Louisiana Medical Mutual Insurance Company (LAMMICO) and active on its Loss Prevention/Marketing Committee. Dr. Johnson is also a past chair and treasurer of the Louisiana Medical Political Action Committee (LAMPAC). Since the summer of 1992, he has represented the physicians of Louisiana on the Louisiana Healthcare Commission.

Born April 3, 1938, in Port

Arthur, Texas, Dr. Johnson received his MD degree from the University of Texas at Galveston where he interned in surgery. Following two years of service with the Army, including duty in Viet Nam, he trained in diagnostic radiology at the Ochsner Foundation Hospital in New Orleans. He is board certified in diagnostic radiology and a fellow of the American College of Radiology. He maintains an active private practice of diagnostic radiology.

Dr. Johnson is clinical associate professor of radiology and otolaryngology at Tulane University. He was cofounder and president of the American Society of Head and Neck Radiology. He also is a past president and past chair of the board of the New Orleans Radiology Society.

Dr. Johnson and his wife, Susan, are the parents of two daughters.

Ready, Set, Go!

Dear Colleague:

Can you believe the changes that continue to occur, day after day, which affect the way we practice medicine? Do you feel a bit uneasy about your future? Do you get a "sick" feeling in the pit of your stomach each time you go to a hospital meeting? or open a letter from an insurance company? or sign for a certified letter? It is very difficult to be "out there" on your own, today.

Is there an easy way out? early retirement? career change? even the recognition of a career-ending disability to make up for all the years you have paid that insurance?

At the **new, energized** Colorado Medical Society, we have a better idea! If ever there was a time for physicians to unify and plan for the future, that time is now. CMS has just begun to take control of the issues which affect our lives. From a strong voice in the legislature to address issues such as non-physician scope of practice, to corporate practice of medicine, to patient access to a physician of their choice...to the negotiating table to deal with HMOs...to development of a patient-physician collaborative effort to change the current climate...to the potential development of a physician-owned, physician-controlled managed care entity to provide the public with better health care at affordable prices, Colorado Medical Society is out there representing the interests of you and your patients.

As I promised last year when I campaigned for the office of CMS President-elect, we will begin a grass roots planning process this spring to

develop our **Program for Work**

which will start at the CMS Annual Meeting this September. This will be our agenda for the first 100 days of my term as CMS President. Dr. David Martz has geared up this Society, and I intend to make it fly!

The process will start at the **CMS Leadership Conference** to be held May 5-7, 1995, at the Sonnenalp Resort in Vail, Colorado. Our keynote speaker will be Daniel "Stormy" Johnson, MD, current Speaker of the AMA House of Delegates, soon to be the next President-elect of the AMA. He will discuss with us Friday night what the AMA is doing to provide physicians with access to patients and will kick off our planning process on Saturday by discussing the value of the planning process for medical societies. We will then hear from four CMS physician leaders who will lead the discussion on different issue areas to be addressed next year. Each attendee will be asked to sign up for one of the four issues, participate in the discussion, and help formulate a set of resolutions to be refined by late July and presented to the CMS House of Delegates for deliberation in September.

If you believe as I do that the time is now for Colorado physicians and their patients to take back control for our health care delivery system and write its future agenda, please attend our CMS Leadership Conference, May 5-7 in Vail. I need your input! For those of you who have called me repeatedly to gripe about your plight and your own perceptions of CMS, now is the time to show up and make your views heard!

Please fill out and return the accompanying registration form, so that together we can work for a better tomorrow. Our patients deserve our help!



Joel M. Karlin, MD
President-Elect
Colorado Medical Society

President-elect's Leadership Conference
Ready, Set, Go!
Developing Our Program for Work
May 5-7, 1995, Sonnenalp Resort, Vail, Colorado

REGISTRATION FORM

Yes, I (we) plan to participate in **Ready, Set, Go!** May 5-7 in Vail and will attend the following:

PHYSICIAN

☐ Friday evening dinner

☐ Saturday/Sunday Conference

SPOUSE

☐ Friday evening dinner

☐ Saturday/Sunday Conference

I am (we are) interested in the following Issue Group(s)—check all that apply; if you select more than one, we will make the final assignment:

Issue 1 – **Patient Access and Fairness** – Tom Allen, MD and Eugene Sherman, MD

Issue 2 – **Integrated Delivery Systems** (IDS) – Bob McCartney, MD

Issue 3 – **Rural Health Issues** – Jack Berry, MD

Issue 4 – **CMS Legislative Efforts** –

PHYSICIAN

☐

☐

☐

☐

SPOUSE

☐

☐

☐

☐

Name _____ Spouse's Name _____

Component Society _____

Mail your completed registration form to:

CMS, PO Box 17550, Denver, CO 80217-0550

Fax: 303-771-8657 or Phone: 303-779-5455 or 800-654-5653

Sonnenalp Resort of Vail

Pre-registration form

Group Name: Colorado Medical Society

Name _____ Area Code and Phone Number _____

Address _____ City _____ State _____ Zip _____

Number in Party _____ Arrival Date _____ Departure Date _____

Credit Card Information:

Please Note: A deposit equal to two night's stay will be charged to your credit card. Balance is due upon check-out.

Check one: ☐ Mastercard ☐ Visa ☐ Diners Club ☐ American Express

Credit Card Number _____ Expiration Date _____

Cardholder's Name as it appears on the card _____

Special Seminar/Conference rate will be extended to attendees for longer stays.

Desired Accommodations:—Bavaria Haus Suites:

☐ King Bed

☐ 2 Double Beds

\$120 per night, Single or Double Occupancy—Number of Units: _____

Bavaria Haus suites all contain gas-log fireplace, large baths with soaking tub big enough for two, separate shower, heated tile floor, walk-in closet, TV, VCR, fully-stocked mini-bar, hand-carved pine Bavarian furniture, and down comforters on all of our beds.

Rates include a full European-style breakfast in the dining room.

There will be an additional charge of \$25.00 per night for each person over 12 years of age exceeding Double occupancy.

(Note: most suite types cannot accommodate more than 3 adults.)

Reservations received after April 14, 1995, will be taken on a space available basis only.

Cancellation Policy: In the event of cancellation 30 or more days prior to arrival, you will incur a \$50 per room penalty in handling charges. In the event of cancellation between 30 and 14 days prior to arrival, you will incur a one-night cancellation fee, if you cancel less than 14 days prior to arrival, you will incur a two night cancellation fee.

Reservations will be taken with this form or call our reservations Department at (800) 654-8312.

Please mail this form to:

Sonnenalp Resort, Attn: Group Reservations, 20 Vail Road Vail, CO 81657

Colorado Medical Society
Leadership Conference
 May 5-7, 1995—Sonnenalp Resort Vail

Tentative Schedule

FRIDAY, MAY 5, 1995

1:30 p.m. - 3:00 p.m.	Finance Committee
3:00 p.m. - 6:00 p.m.	Board of Directors
7:00 p.m. - 7:30 p.m.	Cash bar
7:30 p.m. - 9:00 p.m.	Dinner
-	"What is the AMA Doing to Provide You with Access to Patients?"
	Stormy Johnson, MD

SATURDAY, MAY 6, 1995

8:00 a.m. - 8:10 a.m.	Welcome, Conference Overview—Joel Karlin, MD
8:10 a.m. - 9:00 a.m.	"The Planning Process for Medical Societies"
-	Stormy Johnson, MD
9:00 a.m. - 9:10 a.m.	Creation of "CMS Program for Work" for 1995-96
-	Joel M. Karlin, MD
-	Process for identifying issues and creating resolutions for the Annual Meeting of September 1995
9:10 a.m. - 9:30 a.m.	Issue 1—Patient Access and Fairness Tom Allen, MD (Primary Care) and Eugene Sherman, MD (Specialty Care)
9:30 a.m. - 10:00 a.m.	Audience Impact on Issue 1
10:00 a.m. - 10:20 a.m.	Issue 2—IDS Bob McCartney, MD
10:20 a.m. - 10:50 a.m.	Audience Impact on Issue 2
10:50 a.m. - 11:10 a.m.	Issue 3—Rural Health Issues Jack Berry, MD
11:10 a.m. - 11:40 a.m.	Audience Impact on Issue 3
11:40 a.m. - 12:00 N	Issue 4—Relationships with Legislators
12:00 Noon - 12:30 p.m.	Audience Impact on Issue 4
12:30 p.m. - 2:00 p.m.	Lunch
2:00 p.m. - 2:20 p.m.	Forming Alliances—The Who and How of It
-	Joel M. Karlin, MD
2:20 p.m. - 2:40 p.m.	Patients My Doctor, My Choice Ms. Edy Hughes, CoChair, CMS Patient Advisory Committee
2:40 p.m. - 3:00 p.m.	University Physicians Dick Krugman, MD
3:00 p.m. - 3:20 p.m.	Kaiser Physicians
3:20 p.m. - 3:40 p.m.	Coalition of Physicians (COPS) Ian Levinson, DO, Colorado Society of Osteopathic Medicine
3:40 p.m. - 4:00 p.m.	Other Physician Groups
4:00 p.m. - 4:30 p.m.	Wrapup of day's activities/Thoughts for Sunday
5:00 p.m. -	Dinner/Evening on your own

SUNDAY, MAY 7, 1995

8:30 a.m. - 8:30 a.m.	Where Do We Go from Here? — Joel M. Karlin, MD
8:40 a.m. - 9:30 a.m.	Breakout Groups Issues 1-4
9:30 a.m. - 10:10 a.m.	Report Issue 1 Group—Tom Allen, MD and Eugene Sherman, MD
10:10 a.m. - 10:30 a.m.	Break
10:30 a.m. - 11:10 a.m.	Report Issue 2 Group—Bob McCartney, MD
11:10 a.m. - 11:50 a.m.	Report Issue 3 Group—Jack Berry, MD
11:50 a.m. - 12:30 p.m.	Report Issue 4 Group—
12:30 p.m. - 12:35 p.m.	Concluding Remarks—Joel M. Karlin, MD

..... Time Table for Resolutions from each group:

..... Initial resolution(s) due @ CMS **June 5**

..... Initial resolution(s) distributed to members of Planning Session for comments **June 10**

..... Comments on resolutions due back to CMS by **June 30**

..... Resolutions with comments sent to assigned person by **July 7**

..... Final resolutions due by **July 28**



Orthopædics Overseas:

Transkei, South Africa

(reprinted by permission from The Volunteer Connection, Winter, 1994-1995, Vol. 8, No. 3, published by Health Volunteers Overseas, 202-296-8018)

Introduction: *Colorado Medicine* recently carried a report from Dr. Robert Eilert (February, 1995, Vol. 92, No. 2; pp. 62,63) concerning his experience as a volunteer in Malawi, Africa. We have learned that Fort Collins Orthopædic Surgeon Roger M. Sobel, MD, has had similar experiences in Transkei, South Africa.

Transkei is located in the southeastern region of the African continent and has a population of about 4.5 million people. It is one of the poorest regions of the country—overpopulated and dependent on subsistence level farming. Orthopædics Overseas works with the Africa Medical Mission in Transkei to provide health training at the Umtata General Hospital and Bedford Orthopædic Hospital.

Prior to leaving the United States, I spoke with both Mr. Spence Campbell and Dr. Robert Eaton on more than one occasion and found them to be quite helpful in preparing for the trip. The orientation packet provided by the Washington Office was quite helpful. I found Umtata to have a mixture of cultures with several health workers from other developing countries. Chris and Jennie McConnachie's on-site orientation as well as that of Sister Rosemarie at Bedford Hospital provided a smooth cultural transition.

During my one month tour, our routine was to begin each day with a conference at the Umtata General Hospital that served as a combination of case review, teaching conference, and distribution of work assignments for the day. Following the conference, I would go to the operating room at Bedford Hospital. The operating theater time there was rather strictly adhered to (9:00 am to 3:00 pm) followed by ward rounds at the Bedford Hospital. Transkei was my first real experience in practicing orthopædics in a developing country.

Although I suspect that this would be true of orthopædics in any of the developing countries, I was particularly impressed with the severity and quantity of pathology. Essentially, a population of five million funnels into one orthopædist. In addition to a large volume of neglected trauma, there is a great variety of congenital deformities and pathology that I don't see at home, including tuberculosis, polio and leprosy.

I was pleasantly surprised by the living conditions. We were housed in a rondavel (a thatched roofed hut) on the grounds of the Bedford Hospital and were well-provided for. The housing was both comfortable and a welcome experience in Transkei living. We rented a car and found this to be very advantageous. We had ample time to travel locally on the weekends and visited the beautiful Indian Ocean coast on two occasions.

Overall, my one-month tour was a mixture of elation and occasional frustration, but definitely a worthwhile experience that I would recommend to anyone. I found an almost overwhelming array of severe pathology with an opportunity both to treat and to teach.

In an ideal situation I think more might have been accomplished if I had had a more well-defined role: "This is whom I am to teach and when." However, because of the multiple variables that affected the day-to-day schedule, this ideal situation would have been very difficult to realize. I feel that I accomplished a significant degree of orthopædic care and teaching and I personally gained a great deal from the one month tour. However, to be truly effective, a period of three months would be much more desirable. The experience was excellent and I plan to return either to Transkei or to a similar program in the future.



Scam - Attention Deficit Syndrome

A growing scam in the Midwest usually involves an adult couple, two or more young children, and a clever attempt to improperly secure prescriptions for 20 mg. doses of Ritalin. With some slight variations, the scam follows this basic format:

Families, some on welfare, are recruited, trained, coached and, finally, scheduled for multiple doctors' appointments. Symptoms of Attention Deficit Syndrome (ADS) are described by the adult to the physician. The children readily concur, and play their parts well. Ritalin, not normally recognized as a street drug, is usually prescribed.

Families, who are receiving welfare assistance, are able to charge both the office visit and the prescription costs to the state. The medication is normally sold to the local drug market for \$500 for 1,000 Ritalin 20 mg. tablets. The street dealer then, usually, resells the Ritalin as part of a set (with Talwin NX) to heroin addicts for as much as \$50.00 per set.

Physicians have often found that when they begin prescribing for one family they are soon overrun with new patients requesting treatment of their children for ADS.

Solutions:

Current information from numerous sources, including the American Medical Association (AMA), relating to Attention Deficit Syndrome, review diagnostic techniques, counseling, recommended prescribing, etc. Physicians

should familiarize with this information. The following precaution can also prove useful:

1. If there is an increase in ADS patients in a physician's case load, he might inquire if other local doctors are experiencing similar increases, to verify that this is an indication of a possible scam. This can be done without sharing any information which might violate confidentiality. A referral to local police for investigation may then be warranted.
2. Require new tests and verification of ADS per AMA standards. The importance of making a proper diagnosis cannot be stressed enough.
3. **The prescribing of Ritalin 20 mg. is the key to this scam.** Physicians who began prescribing 5 and 10 mg. and the 20-mg SR (sustained release) tablets actually were told by parents that they wanted the 20 mg plain tablets and would not accept any other strength. (Apparently, the 20 mg. SR cannot be easily abused or resold.)
4. The recording of patient (in particular, parent) information is vital to uncovering the true identity of these people. (Physicians should record all identification numbers possible), plus the usual date of birth and physical description. In addition, verify with schools that children being treated are actually enrolled and attending school.

Local scam artist poses as plastic surgeon

It's not just patients trying to scam physicians. A thirty-nine year old Greenwood Village accountant faces felony charges of third-degree sexual assault and criminal impersonation as well as a misdemeanor count of harassment after he offered free surgical services to two women. One of the women answered a personal ad in a local newspaper for a "blue-eyed medical professional seeking female companionship." She had several lunch dates with the man and invited him to her house one evening to watch videos with her and her roommate.

During a conversation about plastic surgery, the man reportedly offered each of the women either a breast augmentation or liposuction procedure if they would pay the cost of the operating room. He said he needed to take measurements in preparation for the surgery. The women allowed him to take some measurements, but finally asked him to leave and called police after refusing his persistent requests to disrobe.

Rural Health: A CMS Priority

by Jack L. Berry, MD, Chairman
Rural Health Task Force

Introduction:

The Colorado Medical Society Rural Health Task Force is active, meeting regularly, and making progress. We have had the extraordinary good fortune to have physicians (including a resident, medical student, health care administrator and director of the Rural Health Resource Center) in attendance at our meetings to provide excellent and diverse input. Attendees came from all over the state, both urban and rural areas, but primarily rural, and numbered 18 at the first meeting and 20 at the second. Your Colorado Medical Society leadership is involved as well.

Objectives

The objectives of the Rural Health Task Force are:

1. Increase in numbers of physicians in all specialties practicing in rural Colorado.
2. Improvement in the overall environment of rural practice to include a more attractive financial situation and a more supportive personal and professional rural environment.
3. Development of a support network in which the CMS would have a heavy hand to facilitate integration into statewide, managed care networks, computer networks and telecommunication networks.
4. Facilitation of recruiting for rural communities, both with physicians and non-physician providers by establishing an interactive clearinghouse regarding positions available for physicians, nurses and physician's assistants.

Discussion Points

In order to accomplish these objectives, we have had extended discussion regarding the following items:

1. Of utmost importance and priority is for the CMS to seek legislation to improve the financial situation for physicians practicing in the genuinely rural environment. This would include legislation leading to a state tax credit and loan forgiveness program for physicians practicing in the rural environment, and possibly even scholarships for students attending medical school who have committed to practice in a

rural environment. The CMS should actively seek legislation in these areas and the task force has encouraged the legislative committee to do so. This may need to be done next year, as the legislative agenda for this year is extremely saturated. The task force is seeking legislators who would be willing to sponsor such legislation by contacting their individual legislators. The Council on Legislation has been apprised of these issues and is drafting strategy.

2. A letter has been drafted and approved by the Task Force to be sent on CMS letterhead to family practice residency directors within the state of Colorado encouraging them to consider the option of establishing a Rural Training Track residency and documenting the reasons why that residency option would be an appropriate mode of training more likely to produce rural physicians. In an effort to improve the understanding of rural medical students regarding rural practice, Pat Clark, a medical student from Hugo and our medical student representative on the Rural Health Task Force, has by her own initiative and with our encouragement formed a Student Rural Health Network. This is a non-campus organization that maintains a rural health resource book cataloging opportunities in rural medicine. Ms. Clark also plans to extend the scope of her fledgling organization to include members of all classes, and will schedule speakers periodically regarding rural practice. There are currently 25 members from the first year class. We believe the existence of this



organization will do much to assist with communication between rural physicians and medical students to help counter misunderstandings that often exist in the medical school environment regarding rural practice.

3. Ms. Denise Denton, the executive director of the Rural Health Resource Center for Colorado has been an invaluable asset to our Rural Health Task Force in providing information regarding systems and programs already in existence, and how they may be integrated into our efforts to improve rural health care. She has thus far been particularly helpful in areas of information regarding currently existing scholarships and loan repayment programs, telecommunications networks, and other efforts being made by the Rural Health Resource Center to improve rural health care. (Note: *Colorado Medicine* reported in October, 1994 on the activities of Colorado's Rural Health Resource Center, but did not at that time have an address and phone number. Here they are: Denise Denton, Director, Colorado Rural Health Resource Center, 225 E 16th Ave #1050, Denver CO 80203-1604, 303-832-7493, Fax 303-830-7496.)

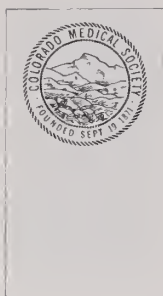
4. The CMS will be instrumental in establishing a familiarization program regarding the use of computers in the rural practice and helping rural physicians become more familiar with computers, and how they may be integrated into their practices to facilitate interaction with state agencies and state facilities including larger hospitals. The

importance of telecommunications in these efforts is being explored by the task force as well.

Many other areas in which the CMS may be helpful in dealing with rural health problems are being explored. A final item of importance to be mentioned in this article is the importance of the CMS assisting rural physicians with integration into the Colorado Physician Network, the managed care organization being created by the CMS. This may provide a particularly useful avenue for integration of rural physicians into a broader network and scope of practice, thus making rural physicians more comfortable.

Your rural health task force will continue working to address these and other issues toward the ultimate goal of providing better, more comprehensive, and much more accessible health care to the people of rural Colorado. Any suggestions from CMS members or others might have regarding issues which should be brought before the Rural Health Task Force should be submitted to the CMS headquarters, attention Marilyn Barton for our consideration.

"The ultimate goal [is] providing better, more comprehensive, and much more accessible health care to the people of rural Colorado."



CMS ALLIANCE



*Patti Brown, President
Colorado Medical Society Alliance*

"Day at the Capitol" A Huge Success



State Senator Dick Mutzebaugh (R-Highlands Ranch) was one of many legislators who took time out to meet physicians and spouses at the "Day at the Capitol".

Many hours of planning and preparation laid the foundation for a successful "Day at the Capitol". Thanks to Rosalie Schreiber, Legislative Day Chairman, Lorraine Koehn, Suzanne Hamilton, and the CMSA county presidents and county legislative affairs chairmen, Colorado physician's spouses and physicians arrived at the Capitol to make "organized medicine's voice heard, and its presence felt". Participants began their day at the Governor's Mansion, where the Lt. Governor, Gail Schoettler addressed the group, before heading to the Capitol building to begin a tour or to listen to action on the floor of the House or Senate.

The highlight of the Day was the opportunity to lunch with your legislators, followed by the all important committee hearings.

Sixty-five Alliance members attended the event. The following

Doctors were able to attend: Joel Karlin, Richard Allen, Ray Painter, Sherry Laubach, David Schreiber, Harvey McClung, Roderic Gottula, David Knize, and Tom Golbert. Several County

Medical executives were also able to attend, as well as Sandi Maloney, Lorraine Koehn, Jerry Johnson, and Suzanne Hamilton.

Unfortunately, the legislative session ran long, and not all the legislators were able to join us for lunch. The extra meals were deliv-



Among those attending were (from l) CMS Lobbyist Suzanne Hamilton, Council on Legislation Chair Richard Allen, MD, Lobbyist Jerry Johnson and CMS member M. Ray Painter, MD.

Alliance members and others were fascinated by the inner workings of the Colorado Legislature.



ered to the Denver Rescue Mission.

Among the legislators present was the Honorable Joyce Lawrence, newly elected Representative from the Pueblo area, who is a physician's spouse. The Honorable Pat Sullivan, M.D. was also able to attend. The other physician member of the legislature, the Honorable Ben Clark M.D., couldn't make it.

Thanks very much to all of you for attending. The CMSA hopes you were able to sharpen your "grass-roots lobbying skills", and that you will continue to develop and utilize those skills.

Physician's Financial Bulletin

Special Insert Number 7 for
Colorado Medicine, March, 1995

An exclusive member service of the Colorado Medical Society in collaboration with Chase Manhattan Investment Services, Inc.

Structuring Your Retirement Portfolio

by Kathy Buys

If you're retired or about to retire, planning and saving for retirement shouldn't stop with your last paycheck. When your work days end, your financial planning should not. That's the time to re-evaluate and adjust your portfolio to maintain the income you need for the lifestyle you've chosen.

One of the biggest mistakes many retirees make is getting too conservative with their investments when they stop working. But that strategy has its own risks: The combination of low real rates of return (return minus inflation) on money market funds and other short-term accounts in addition to longer life expectancy could leave you short of funds during your retirement years.

First, work out a budget. Create a cash emergency fund, using savings accounts, CDs, money market funds and the like to cover your basic expenses. Invest the rest of your assets in longer-term securities. Consider working with a financial consultant to learn more about inflationary projections. This will help you estimate how much you'll need for all the activities you have planned for the years ahead. You can then discuss investments that are suitable for your goals and investing temperament.

Where should you invest? Asset allocation can help you decide. It's the strategy of determining how much money to commit to different types of securities to help accomplish your varied investment goals, given your resources, goals and risk tolerance. By diversifying your

funds among a variety of investments, you should earn a relatively higher return with less risk than if you had put all your money in one investment.

Asset allocation is a strategy you can practice for your entire investing life. And it becomes even more important after you're retired; allocating a portion of your portfolio to quality investments that are more aggressive than money market funds gives you greater opportunity for maintaining your lifestyle.

Consider allocating portions of your portfolio to high-grade corporate or government bonds. They provide dependable, competitive income. In addition, it's a good idea to vary the maturities of your bonds so you don't have to reinvest all your assets at once.

This practice, called *laddering*, helps maintain your current income and spreads your risk out over time. You can also take advantage of changing interest rates because you reinvest maturing bonds more often.

Diversifying your portfolio with bonds helps you earn a dependable level of income that's higher than you'll find on your cash-equivalent investments. Among the bonds



continued on following page...

Market Data

Indicator	12/31/94	2/7/95
Prime Rate	8.50	9.00
CD (180 day rate)	5.76	6.36
6 month T-bill	5.88	6.35
30 yr. T-bond	7.50	7.50
DJIA	3834.44	3937.30
S&P 500	459.27	480.81

This information is obtained from sources we deem to be reliable

Mortgages-New Purchases

No discount fee - No obligation fee

	2/7/95	2/7/94
30 year fixed	9.59%	6.7%
7 year fixed	9.0%	6.125%
5 year fixed	8.5%	6.0%

These rates are subject to change without notice.
Chase Manhattan is an

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Retirement Portfolio...

...from previous page

that may be suitable for your portfolio U.S. Treasury, corporate and tax-free municipal bonds, as well as taxable and tax-free zero-coupon bonds. For greater diversity, consider investing in international debt instruments as well. Also, relatively stable dividend-paying stocks of utilities and blue chip companies as well as preferred stocks can be other sources of investment income. You can invest in these securities individually or through mutual funds, unit trusts and annuities.

Also talk with your financial consultant about allocating a portion of your retirement portfolio to quality growth stocks. It's important to build capital growth as well as income into your post-retirement investments in order to keep ahead of inflation.

Some retirees may be apprehensive about investing in stocks because they do not want to risk their funds in anything they don't consider "safe". While stock returns fluctuate year to year more than other investments, over time they help increase the return on your retirement assets. And when you consider that you may live in retirement for perhaps 30 years, being well diversified becomes that much more crucial. Stocks outperform other financial instruments most of the time, especially the longer you hold them. But remember, past performance is no guarantee of future performance.

A special type of stock, a preferred may be of particular interest, so let's look at them in greater detail:

Q: How is a preferred stock different than a bond?

A: Many preferred stocks have a par value of \$25, which is substantially lower than the standard \$1000 par value of a corporate bond. This allows you to buy and sell small dollar amounts with relative ease. Quarterly income payments are set at the time of issuance and are equal either to a stated dollar amount or to a rate. For example, a preferred with a par value of \$25 paying 8% yield would pay an annual dividend of \$2, or a quarterly payment of \$0.50. Preferred stocks are rated by investment rating agencies like Moody's and Standard & Poor's.

Generally prices of preferred stock tend to move in tandem with long-term corporate bonds. They fluctuate with changes in interest rates, the issuer's credit rating and supply and demand.

Most preferred stock is perpetual, meaning that there is no stated maturity and the fixed dividends will be paid indefinitely. However, issuers may call (retire) outstanding preferred issues at a pre-determined price, much the same way they retire bonds. When interest rates fall, issuers call preferreds and replace them with newer, lower-cost securities.

Perpetual preferred stock tends to yield more than preferreds with call features. Ordinarily, an issue will refund stock when interest rates fall substantially below the level at which they were first issued. However, issuers often grant investors five or 10-year call protection at the time issuance. The initial call price usually is at or above the issue price. If a preferred stock has a call feature, you need to be aware of its current price in relation to its call price.

There are different types of preferred stock. The different features of the various types of preferred stock affect their price volatility in the marketplace.

Cumulative preferred: Stockholders have the right to missed dividends. If the company has a poor quarter and chooses not to pay a first-quarter dividend, cumula-

tive preferred holders would receive their first quarter dividend at a future date.

Straight preferred:

Dividends are

fixed for the life of the security. Missed dividends are not paid later.

Participating preferred: Shareholders have the right to any earnings in excess of the stated dividend.

Convertible preferred: Holders may swap this preferred stock for a predetermined number of common stock. Because the number of convertible shares is fixed, prices on these preferreds generally fluctuate more.

Adjustable rate preferreds: Dividends are reset each quarter. Adjustments are subject to minimum and maximum limits ("collars"). This market is more limited and less liquid than most perpetual preferreds.

Foreign preferred: Foreign entities issue American Depositary Shares (ADS) and preference shares, denominated in U.S. dollars. They typically offer higher fixed dividend rates than domestic preferreds. Many provide a 15% - 20% tax credit on a portion of the dividend.

It's important to build capital growth as well as income into your post-retirement investments in order to keep ahead of inflation.

Mortgage Alternatives

by Laura Meyer
Chase Manhattan Personal Financial Services

A popular alternative to a fixed mortgage is an adjustable-rate mortgage (ARM) loan, which provides for an extended initial interest rate period. While there is a wide variety of these, we will focus on the five year ARM.

The initial interest rate for these loans is in effect for an extended period of time and is not based on the index used to make interest rate adjustments in later years. This initial interest rate could be higher or lower than, or the same as, the interest rate that would result from using the index rate published in the latest Federal Reserve statistical release issued at the time the initial interest rate is established for a particular loan. Whether the initial interest rate is higher, lower, or the same depends on market conditions existing at that time.

An ARM loan is a variable-rate loan with a 15-, 20-, 25- or 30-year repayment period, during which time the interest rate and monthly payments of principal and interest may vary. During the first five years (60 months) of the loan, the interest rate and monthly payments will remain fixed and will be set in the promissory note you will sign. Beginning with the first day of the 61st full month of the loan and on that same date every 12 months thereafter, the interest rate may be adjusted to correspond to movements of an index rate. The index rate can increase or decrease as economic conditions change.

Each time the interest rate is adjusted, the new interest rate will be determined by taking the applicable index rate and adding to it a certain number of percentage points called a "margin". If the sum of the index rate

and the margin is more than the then-current interest rate on the loan, the interest rate will increase. If the sum is less than the then-current interest rate on the loan, the interest rate will decrease. Adjustments to the interest rate will be subject to the interest rate limits described on the following pages. Monthly payments of principal and interest will be adjusted to reflect any increase or decrease in the interest rate.

How Your Interest Rate and Payment Are Determined

For the first five years of the loan

- For the first five years of the loan, the interest rate will not be based on the index rate used to make later adjustments. The initial interest rate will be a discount rate. This means that your initial rate will be lower than it would be if we added the margin to the index rate used to make later adjustments. It also means that the interest rate and monthly payments could increase at the end of the first five years even if the index rate remains the same.
- Each of the first 60 monthly payments will be in an amount that would be necessary to pay the initial loan balance in full at the end of the loan term in substantially equal monthly payments, assuming that the initial interest rate were to apply for the whole loan term. The term "monthly payments", as used in this summary, refers only to payments of principal and interest.

continued on following page...

Interested in Managed Mutual Funds?

If you are interested in a method for managing your no-load mutual funds you should plan to attend a seminar to discuss this important topic.

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Executive Conference
Room, 2000 South
Colorado Blvd, 12th
Floor

When: March 16th

Time: 6:00 pm - 8:00 pm

Refreshments will be served.

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After the first five years of the loan

- Beginning with the first day of the 61st full month of the loan and on that same date every 12 months thereafter, your interest rate may increase or decrease to reflect any changes in the index rate. Each date on which the interest rate may change is called a "change date". Your interest rate will be determined by taking the index rate and adding the margin to it.
- The index rate for determining the interest rate is often the weekly average yield on United States Treasury securities adjusted to a constant maturity of one year, as published by the Federal Reserve Board in Statistical Release No. H. 15(519), which is available from the Federal Reserve Board, Publication Services, Washington, DC. 20551.
- The margin will remain constant for the term of the loan.
- On each change date, we will set the interest rate on your loan for the next 12 months by taking the index rate published in the latest Federal Reserve statistical release issued 45 days prior to the change date, adding the margin, and rounding the total to the nearest 1/8th of 1 percentage point. The total will be your new interest rate unless the interest rate limits on the loan restrict the amount of any change. These limits are discussed in the next section, *How Your Interest Rate Can Change*.
- Your monthly payments of principal and interest will be based on the then-current interest rate, loan balance, and remaining loan term and will be the amount necessary (at that interest rate) to repay the loan in full at the end of the loan term in substantially equal monthly payments.

How Your Interest Rate Can Change

After the first five years of the loan, your interest rate can change yearly in accordance with increases or decreases in the index rate, subject to the following limits:

- On the first change date, the interest rate will not increase or decrease more than 4 percentage points above or below the initial interest rate.
- Starting with the second change date, the interest rate will not increase or decrease on any change date more than 2 percentage points above or below the rate of interest you have been paying for the preceding 12 months.
- Over the term of the loan, the interest rate will not increase or decrease more than 4 percentage points above or below the initial interest rate.
- The minimum interest rate change increment will be 1/8th of 1 percentage point because of the rounding to the interest rate.

How Your Monthly Payments Can Change

- After the first five years of the loan, your monthly payments of principal and interest can change yearly, based on a change in the interest rate. Whenever your payment changes, the new payment amount will be the amount necessary (at the new interest rate) to repay the loan in full at the end of the loan term in substantially equal monthly payments.
- You will be notified in writing of any payment change at least 25, but no more than 120, days before the due date of a payment at a new level. The notice will contain information about the index and interest rates, payment amount, and loan balance.

Kathy:

Please contact me in regards to (please circle)

Home Mortgages

Equity Line of Credit

Education Debt Refinancing

Tax Planning & Strategies

Financial Planning

Insurance

Estate Planning

Trust Services

Portfolio Analysis/Investments

Retirement Plans

Auto Finance

Name _____

Address _____

Phone: (H) _____ (W) _____

Best time to contact: _____

(DENVER)

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PF Bulletin

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CMS



CHASE



Is the Pen Mightier than the Keyboard?

Will electronic pens displace the computer keyboard? In David Bauer's Northridge, California family practice, the keyboard now takes second place.

Pen-based systems allow users to write on a screen with an electronic pen while the software attempts to recognize this handwriting and convert it to text. Hardware ranges from hand-held personal digital assistants and slate-style units, to laptop lookalikes.

Imagine this. A patient arrives at his physician's office, the receptionist touches the patient's name on her computer with a pen, alerting the back office that the patient is ready to be seen. Meanwhile, instead of writing telephone messages on a message pad, she uses the pen to write a message on her screen, then sends it to the appropriate individual by tapping their name with her pen.

The medical assistant places the patient in a room and takes his vital signs. Instead of writing vital signs in a paper chart, she carries a pen-based computer, and writes the vitals in the patient's electronic chart. She may also glance at the patient's medication list and inquire about any changes. By crossing out an existing medication and writing in a new one, she updates the patient's chart. She can then carry

the unit to the next room to repeat the process. Wireless network adapters make this possible.

The physician's screen updates to show that the patient is in the room and is ready to be seen.

The physician examines the patient and decides to order an EKG and blood work. A few more touches of the pen transmit these orders to the medical assistant and laboratory technician. At the same time, the physician is writing his progress note on the pad. He calls up a stored anatomical drawing and uses the pen to sketch the location of two suspicious skin lesions. At the conclusion of the visit, the physician enters a diagnosis and documents changes. He also writes a note with the pen to the receptionist that the patient is to return in two weeks. The receptionist has that week's appointment schedule on the screen when the patient arrives back at her desk before leaving the office.

On the following Sunday, the pharmacist calls to confirm a prescription and the physician's on-call partner dials into the office system to read the prior week's patient's progress note and medication list. He notes a potential drug interaction and modifies the prescription accordingly.

If this scenario sounds like the

"Features available include full patient electronic medical records, free-hand drawing, anatomy templates, drug formularies by insurer, electronic prescription writers with faxing capabilities, patient education instructions, work and school excuses, SOAP notes, graphing vitals, and more."



from previous page...

Physician's Online tops 50,000 physician subscribers

Landmark Communications of Norfolk, Virginia has announced that it has acquired a minority interest in *Physicians' Online*, an interactive service providing information to physicians. Sheryle Bolton, President of Physicians' Online, says the service "helps physicians respond effectively to patients' problems and concerns at the point of need, anytime and anywhere."

Both Physicians' Online and Landmark say the investment will help them better serve the needs of physicians and patients. Currently, services include free, unlimited use of core medical reference services, such as MEDLINE®, AIDSLINE®, Physicians' GenRx™, Quick Medical Reference®, Prescribing Decision Module Support™ and drug interaction programs. Additional features will include full-text journals and textbooks, online continuing medical education programs and a customized clipping service. For more information about Physicians' Online, call 1-800-332-0009.

future, think again.

Last year, more than 1,000 healthcare professionals were surveyed at the Healthcare Information and Management Systems Society (HIMSS) meeting in Phoenix to find out where healthcare computing is headed in the future.

When asked, "Which emerging computer user interfaces will experience the most rapid growth in the next two years?," 30 percent said "pen-based systems," the largest single category.

Today, Dr. Bauer and other physicians like him are on the leading edge of that trend, and the technology is available from a variety of pen-based application developers.

Dr. Bauer has compared five pen-based programs and published his findings in this month's issue of *Medical Software Reviews*.

"Before purchasing a pen-based system, or any other electronic patient chart system, first determine exactly what your needs are," says Dr. Bauer.

"Do you want to completely replace your current paper chart? Do you want to carry with you (on a portable hand-held device) information about the patients whom you will be seeing in the hospital today? Do you want to be able to explore the demographics of your patients? Does the program have to integrate with your practice management and billing software? Without answering these questions, you may end up with an excellent program that doesn't meet your needs!"

Features available include full

patient electronic medical records, free-hand drawing, anatomy templates, drug formularies by insurer, electronic prescription writers with faxing capabilities, patient education instructions, work and school excuses, SOAP notes, graphing vitals, and more.

The five pen-based electronic patient chart programs reviewed are *MedWorks* from Pen Based Medical Networks, *Hippocrates* from Healthcare Communications, *MedTouch for Internal Medicine*, from Med-Touch, *MicroDoc*, from MicroDoc, and *Physician's Assistant* from Auxiliary Systems.

The review discusses the features of each system, ease of use and installation, available documentation, error handling, hardware requirements and general recommendations.

Copies of the review are available from *Medical Software Reviews* at \$10 each.

Medical Software Reviews is an independent, unbiased, monthly newsletter that evaluates medical software programs available for use by healthcare personnel. All reviews are written by practicing clinicians. The publication does not accept advertising and is not associated with any vendor. *Medical Software Reviews* is published by Healthcare Computing Publications at 462 Second Street, Brooklyn NY 11215-2503. Telephone (718) 499-5910. Fax (718) 768-3260.



Supplemental Security Income Benefits For Premature Infants

Many premature infants with very low birth-weights may be eligible for Supplemental Security Income (SSI) benefits. SSI is a federal program that pays monthly checks to aged and disabled people. SSI isn't just for adults. Monthly checks can go to disabled children too. Premature infants weighing less than 2 pounds, 10 ounces at birth are considered disabled. Premature infants weighing between 2 pounds, 10 ounces and about 4 pounds, 6 ounces at birth may be considered disabled if they are small for their gestational age and have serious medical problems. These infants may be eligible for SSI up to 12 months of age.

SSI is a "needs based" program. Normally, the parents' income and resources are considered in deciding whether a child is eligible for SSI. However, when a very small, premature baby remains in the hospital after birth, the parents' income and resources are not considered in deciding whether the baby is eligible for SSI. This is because a child must first "live with" the parents for the parents' income and resources to be used in deciding the baby's eligibility. So, these very small, premature, hospitalized babies may be eligible to receive SSI monthly payments.

When these premature babies go home from the hospital, they may still get SSI benefits if the parents' income and resources are less than the limits set for SSI eligibility. More than half the babies who become eligible for SSI while in the hospital, continue to receive SSI after they go home.

Medicaid Coverage

Another possible benefit for these infants is Medicaid, which can sometimes be more important than the SSI check. Medicaid is a government medical insurance program which can help pay for the infant's hospital bills. In Colorado, the very small, premature infants who become eligible for SSI checks get Medicaid coverage automatically. This is not always true in other states.

For some babies who already have Medicaid at birth (because their mother has Medicaid), the baby will receive a smaller SSI monthly check while in the hospital. Usually, when these babies with Medicaid at birth go home they will still receive SSI and the amount of the SSI payment may be increased. So, it is really important for Medicaid-eligible babies to be enrolled in SSI while in the hospital.

The Special Case of Public Hospitals

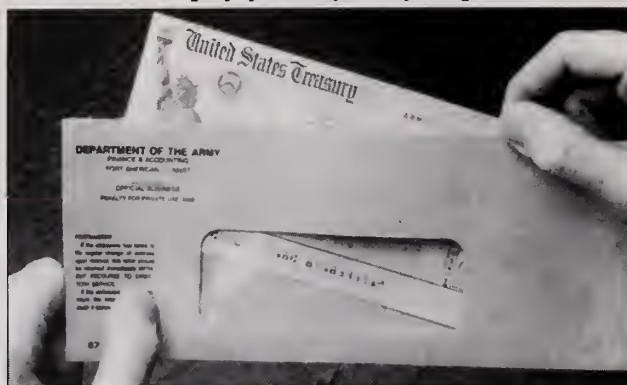
The kind of hospital that a baby is in can affect whether the baby receives SSI. If the baby is in a public hospital and the baby's family has private health insurance which is going to cover over half of the baby's hospital bill, the baby will not be eligible for SSI. On the other hand, if Medicaid is going to pay for more than half the costs, the baby may be able to receive SSI payments in the hospital and usually after going home.

How to Apply in Colorado

Parents of very small, premature infants who may qualify for SSI should submit an application as soon as possible after the infant's birth. The hospital social worker in the Neonatal Intensive Care Unit should have a special SSI application form which should be used. A hospital staff member will help the parents complete the forms and mail them to Social Security. If the hospital does not have the SSI application package, the parents should contact Social Security at 1-800-772-1213 as soon as possible after the infant's birth. The parents should request an appointment to apply for SSI for their new baby. The date of this phone call will be the first day for which SSI can be paid. The parent should write down the date and time of the call and the name and location of the Social Security person who talks to them.

SURGEONS: COULD YOU USE AN EXTRA \$10,000?

If you're a resident in surgery, the Army Reserve will pay you a yearly stipend which



could total in excess of \$10,000 in the Army Reserve's Specialized Training Assistance Program (STRAP).

You will have opportunities to continue your education and attend conferences, and we will be flexible about scheduling the time you serve. Your immediate commitment could be as little as two weeks a year, with a small added obligation later on.

Get a maximum amount of money for a minimum amount of service. Find out more by contacting an Army Reserve Medical Counselor. Call:

Major Jeff Sutterfield
Call Collect (303) 361-3889

ARMY RESERVE MEDICINE. BE ALL YOU CAN BE.®

Women in Medicine Learn to Laugh and Lead

"I've had enough of glass ceilings, sexual harassment issues and health care reform," says Deborah K. Bublitz, MD, chair of the CMS Women in Medicine Section. "Let's get together and laugh."

The occasion for this jocularly will be the Women in Medicine Section's dinner and **Interim Business Meeting** March 10. Humorist Craig Zablocki will show how humor can help reduce stress and aid women physicians in coping with rapid changes in the profession and in their dual roles. The physicians will also review resolutions that have been submitted to the CMS House of Delegates and elect members of the Women in Medicine Governing Council.

April 22 will be the date for the **Women Physician's Leadership Conference**. The featured speaker will be Dorothy Cantor, PsyD, author of *Women in Power: The Secrets of Leadership*. All women physicians are invited to attend. In addition to the main presentation, there will be four mini-sessions: advancement and promotion for women physicians; management styles, collaborative versus controlling; Venus and Mars, female brain/male brain communication; and creative problem solving for women.

The leadership conference costs \$25 (including breakfast and lunch) and pre-registration is required. Free child care is available. Call Marilyn Barton at 303-930-0407 or 1-800-654-5653, extension 407 for details.

Memo

To: **President Clinton
Members of the House and Senate**

From: **The 300,000 member physicians of the
American Medical Association**

Re: **Getting the job done on health care**

We believe there are several workable measures that can be passed now to help achieve our ultimate goal – making quality health care affordable and accessible to all Americans.

As the country awaits the State of the Union address, the member physicians of the American Medical Association set forth these practical recommendations to improve health care for our patients.

Insurance Reform – Pass insurance reforms that will make sure Americans will not lose their coverage if they change jobs or get sick.

Medicare Reform – Reform our Medicare system so it will be there for the next generation of elderly and disabled.

Medical Savings Accounts – Make MSAs available so people can pay for routine medical care with pre-tax dollars.

Patient Protections – Enhance patient choice, disclosure and assure greater physician involvement in corporate decisions about patient care.

Liability Reform – Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

Regulatory Relief – Free both physicians and patients from the ever-increasing burden of needless and wasteful paperwork, regulations, obsolete anti-trust rules and red tape.

Medical Education and Research – Protect medical education and research so that we can find cures for killers like AIDS and cancer.

Public Health Problems – Fight social problems like violence and smoking — problems that cost billions of dollars and millions of lives.

These measures are sensible things we can do now that will make a difference for all of us. So, as we begin our nation's 104th Congress, we renew our pledge to the health of America. As the voice of the medical profession, we pledge to do everything we can to help make these things happen. It is our contract with America, and we fervently hope that every American will join us.

American Medical Association
Physicians dedicated to the health of America



Let's Make the Best Better

James H. White
Grand Junction, Colorado

First Monthly Winner in the CMS Essay Contest

Introduction: In response to a resolution from Arapahoe Medical Society at the Annual Meeting in September, the Colorado Medical Society established an essay contest on health care reform. After plans were finalized by the Executive Committee on January 4, 1995, news releases and other information went out to various media outlets in Colorado. The idea behind the contest was to get input from the end users of health care (your patients) concerning how the system should work. The response indicates that patients are grateful their physicians desire their opinions and input.

Here we publish the first of three monthly winners (and some excerpts from other entries). Mr. White and two others will receive checks for \$100 for their entries. There will also be a grand prize of \$500 and a second prize of \$200, to be awarded in June.

The United States has the best health care system in the world. Our physicians, nurses and technicians are among the world's best trained, and their ratio to the total population is high. Our hospitals and clinics are equipped with the latest equipment and operate under the highest standards. Each individual is free to select the care that most appeals to him or her.

The system is not, however, perfect. There are two broad areas where we can and should be striving for improvement. The cost of health care is escalating at an alarming rate, and it is not uniformly available to all people. These two areas are obviously inter-related and must be addressed simultaneously. Broader availability of care will depend on slowing the rising costs, but neither must be achieved at the sacrifice of quality.

The health care system, consisting of practitioners, institutions and the insurance industry, must work as a unit to improve its efficiency and broaden its availability. Attempts must be constantly made to improve cooperation between the various entities and to standardize the hopeless maze of paper work now required. In this effort government must be supportive but not controlling, and its role must be restricted to enabling and encouraging the system to operate at its highest level of efficiency.

Probably the most important improvements must be made by the people — the patients. Our own lifestyles have done much to stimulate the demand and drive up the cost of care.

The general public must be better educated and each individual must assume more responsibility to reduce the demand for expensive treatment. If we could eliminate the use of tobacco and street drugs, radically improve our diets, use alcohol more sensibly, curtail sexual promiscuity and have all of our children immunized, much of the demand for healing treatments would decline. Another significant reduction in the demand for care could be realized by more attention by individuals to accident prevention and more conscientious use of protective equipment on the highway, at work, at play and in the home.

An ideal system would be managed health care, based on regular check-ups throughout each person's life, prevention of avoidable problems and early detection of inevitable conditions.

#

Here are portions from some of the other entries we have received so far:

Planning Ahead Health Care

"[N]ewborn Bill. At birth he was given a social security number. ...When Bill becomes of working age...his employer, at his request, will withhold the amount requested from Bill's check and deposit it into the fund arranged for at birth. Much like our Social Security Plan, the employer, by law, will match the

"There are two broad areas where we can and should be striving for improvement. The cost of health care is escalating at an alarming rate, and it is not uniformly available to all people."

withholding taken from Bill's check and credit it to Employee Insurance Benefits."

Lee Conley, Clifton

The Healer as Teacher

"Through the centuries, starting with the discovery of disease-causing bacteria, the development of astronomically expensive technology has fostered the myth that every disease can be conquered if you just have enough sophisticated tests and treatments. Current data does not support the myth. ...Sad to say, but it's a rare doctor who has enough curiosity and time to teach patients how to take care of themselves. The doctor's most powerful medicine is himself, his ability to model a healthy lifestyle."

Nonie Birkedahl, Grand Junction

Health Care Program

"A patient would have access to health care in any "District" in the state. However, if health care costs were more in the "District" they choose, they would have to make up the difference. There would be an up front fee for doctor calls. Each "District" would conduct a survey to determine the number of inadequately insured and uninsured for funding by the state. The Medicaid information could be established through Social Services. Pre-existing conditions and catastrophic illness would be funded by a luxury tax that includes alcohol and tobacco."

Felix Sefcovic, DeBeque

Discount or Rebate?

"Each time I receive a bill to pay a premium on my automobile insurance, I always notice the deductions at the bottom of the statement. 'Your premium has been reduced because of "Accident free" and "multi-car" discounts.' Why cannot the same principle be applied to health insurance? 'Your premium has been reduced because of "illness free year" or "preventive claims only"'. Routine physical examinations might also be included."

Alfred (Bud) Root, Grand Junction

Nothing Personal

"It's kind of funny that doctors and lawyers ...are finally getting the disrespect that many of them deserve. I own an automotive repair business, so I know how the uncaring and money driven people in your business give even good doctors a bad name publicly, no matter how hard the good ones try. ...I have a son who has asthma. ...I was compelled to find someone who would help Chris and most important of all be able to remember his first name. Thank God for the professionals at the National Jewish Hospital. ...After a week of nothing but tests, using equipment and specialists who all had time to do their jobs right, we found out what was making Chris sick. ...We came back to Grand Junction determined to find a doctor who cares more for people than money. We found him. His name is Dr. Etcheverry and his patients, just like every customer that walks into my business are taken very personally."

Mike Bambino, Grand Junction

If your patients wish to enter the contest, have them submit an essay of 500 words or less to: Essay Contest, Colorado Medical Society, PO Box 17550, Denver, CO 80217-0550. Entries become the property of the Colorado Medical Society. Employees and members of the Colorado Medical Society (except medical students) and their families, employees of Copic Insurance Company and Agency, and members of the Colorado General Assembly are not eligible to win.

Thinking About Travel?

If you're thinking about travel or planning
tours or vacations, then let
Colorado Medical Society
help you chart your course.

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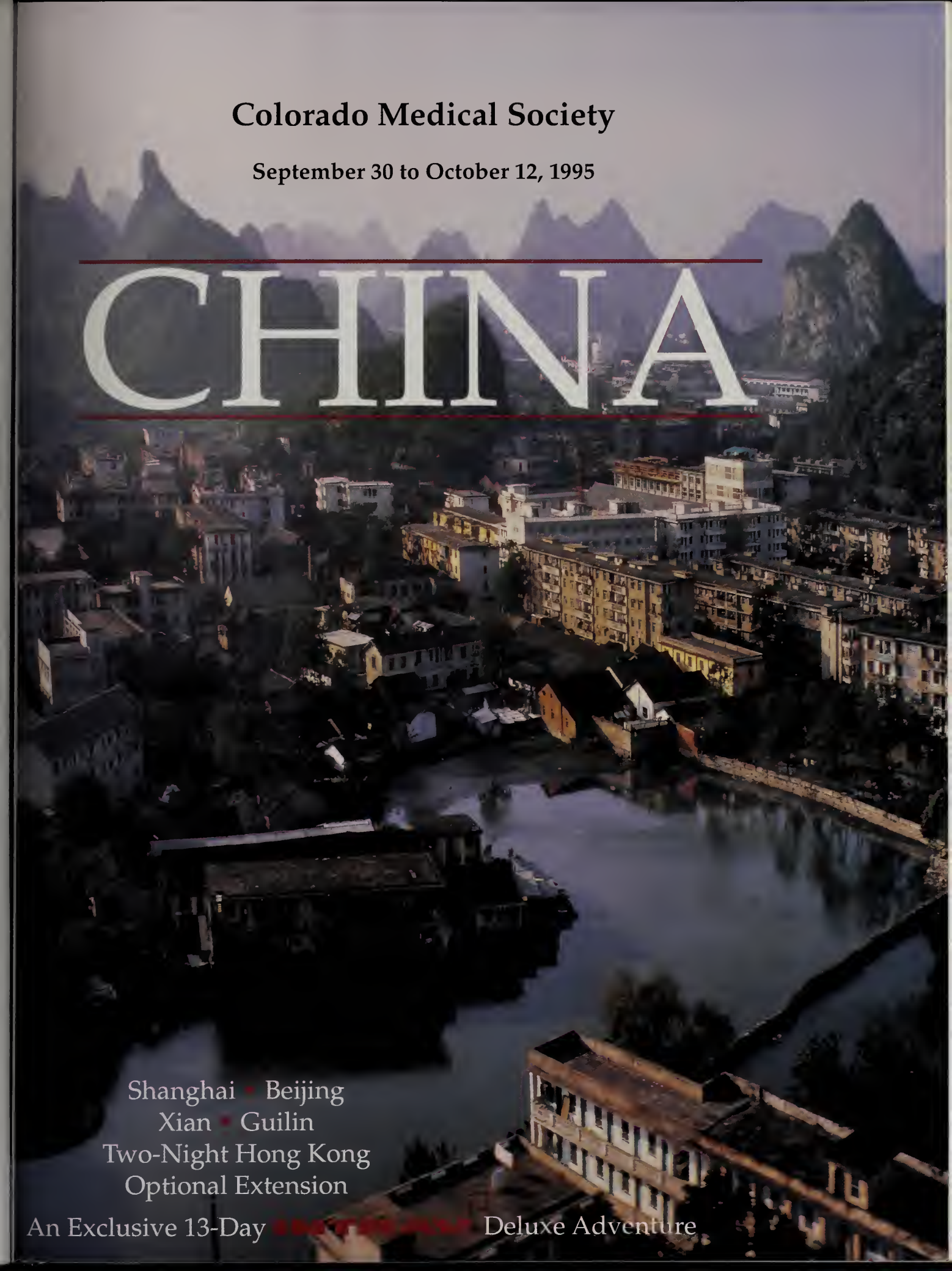
to bring CMS members the highly specialized design and operation of travel
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Attractive brochures describing these programs will be mailed periodically
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An aerial photograph of a Chinese city, likely Guilin, showing a winding river through a dense urban area with traditional and modern buildings. In the background, there are iconic karst mountains under a hazy sky.

Colorado Medical Society

September 30 to October 12, 1995

CHINA

Shanghai • Beijing
Xian • Guilin

Two-Night Hong Kong
Optional Extension

An Exclusive 13-Day ~~2007-2008~~ Deluxe Adventure

See the Very Best of C



A



B



C

A: Xian's cache of terra-cotta warriors is an amazing artistic accomplishment. B and C: The smiles and children will captivate you. D: See the brilliant mosaics at the Temple of Heaven in Beijing.

Shanghai

Beijing

On One Exclusive Trip

Experience the fascinating People's Republic of China on one of the most comprehensive tours of this country. Both the major cities and tranquil countryside are featured on this exclusive 13-day itinerary. If you only visit China once, this adventure is the trip of a lifetime.

Visit major historical sites, museums and parks, and observe the daily life-style and culture of the Chinese people.

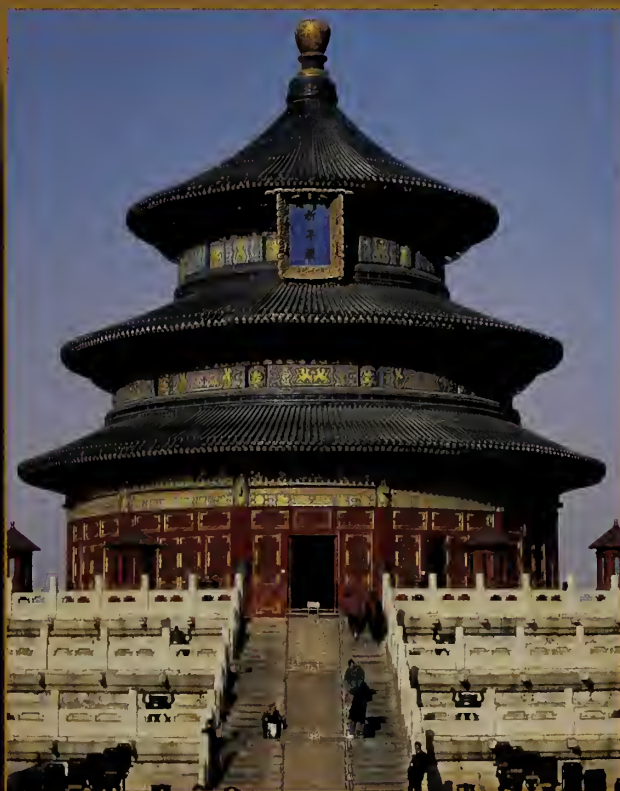
All Sightseeing Included

During your journey through the best of China, a full program of sightseeing is included every step of the way. Observe the clatter and commerce of Shanghai. Stroll along the famous Bund — the city's bustling boulevard that follows along the west bank of the Huang p'u River.

Then explore Beijing, where China's sense of history and tradition is evident in the city's massive landmarks. Delve into the mysteries of the Forbidden City, where imperial dynasties ruled from golden palaces. Walk on the Great Wall, one of the most amazing achievements of the world. See Tiananmen Square, the Temple of Heaven, Summer Palace, Peking University and the Ming Tombs.

In Xian, visit the imperial tomb with its life-size army of terra-cotta warriors, among China's most significant archaeological finds. Then learn about the region's history at the Shaanxi Historical Museum.

Revel in the beauty of southern China with a stay in Guilin, arguably the number-one scenic spot in the country. During a full-day River cruise, witness daily life along the shores and behold nature's splendor so evident in the region's classic landscape.



D

Xian



Guilin

China... the Convenient and Co



Begin your journey through China in cosmopolitan Shanghai.

Shanghai

Your travels begin with two nights in Shanghai, the largest city in the People's Republic of China. Boasting tree-shaded avenues and lovely green parks, Shanghai is also the

country's most European city. At one time, the city was divided into several national concession districts: American, English, French and German. Your first evening in this big city is enhanced by a **Welcome Reception** at your hotel, the deluxe **Shanghai Hilton**. Offering air-conditioned guest rooms with all the comforts of an international Hilton, your hotel is the perfect base for exploration.

The most popular and fashionable avenue is the one along the Huang p'u River waterfront in the heart of the city. Old and young Chinese gather here to stroll or talk with foreign visitors. The Yu Yuan, a beautiful garden area characterizing the architectural style and landscape art of the Ming and Qing dynasties, is also a highlight of the city.

Visit the Worker's Residential Area, then see the charming Children's Palace — an institute where children obtain extracurricular training in music, dance, art and gymnastics under the guidance of highly trained tutors. You can also enjoy a look at the Jade Buddha Temple. The true flavor of the city can be savored during a **Theatrical or Acrobatic Show** presented the second evening in Shanghai.



China's imposing Great Wall snakes its way across the mountains north of Beijing.

Comfortable Way



Chinese acrobatic show

Beijing

A town for 3,000 years and a capital for seven centuries, Beijing is the second-largest city in China and your second stop on this comprehensive itinerary. Spend three nights in comfort at the **Shangri-La Hotel**, which features

luxurious air-conditioned rooms, all the modern amenities, and several specialty restaurants.

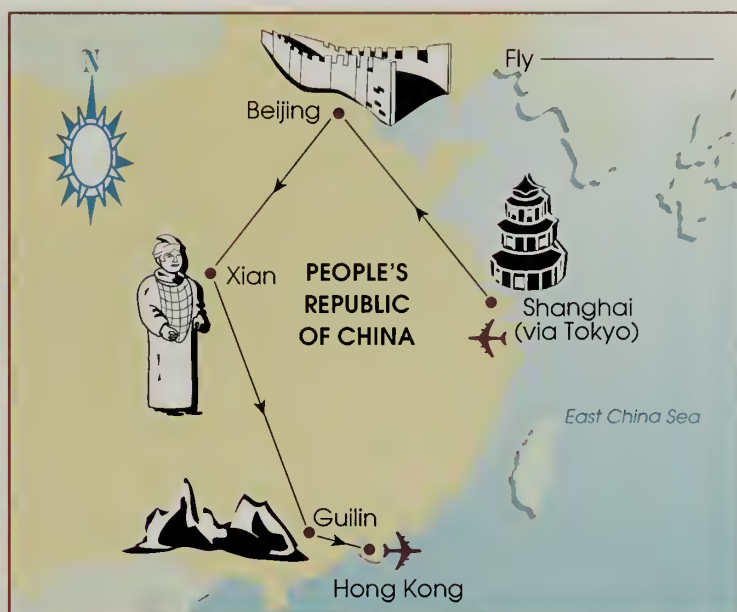
The seat of the strongest central government in China's history and the country's political, administrative and cultural center, Beijing is a city that is a new symbol of a progressive future while still honoring rich in legacies of the past.

The first morning in Beijing, find yourself standing in Tiananmen Square, site of Mao Tse-tung Memorial and the Great Hall of the People. Next, stroll through the Forbidden City, the imperial walled palace of the emperors. This complex is a treasure for tourists and an abiding symbol of traditional China. Enjoy a **privately arranged visit to Peking University**. Then see the Summer Palace, a 700-acre complex where the imperial court stayed during summer months.

On a full-day tour, walk on the Great Wall of China, which snakes its way across the mountains north of Beijing. It is the only man-made object visible from a spacecraft orbiting Earth, and it remains one of humanity's most astonishing accomplishments. Also photograph the sculptured stone pillars that line the Sacred Way to the Ming Tombs, burial grounds for Ming emperors. Here begins the famous "Avenue of Beasts" — lions, camels, elephants, horses and two sets of mythical beasts line each side of the road, alternately standing and kneeling.



China honors tradition.



Finally, explore the Temple of Heaven, a masterpiece of 15th-century architecture. Inside the gates are the Hall of Prayer for Good Harvest, the Temple of the Gods and the Round Altar.

Xian

Early in its history Xian, situated in the Wei River valley, was the starting point of the well-known Silk Road, which linked the West and the East by promoting friendly relations between ancient China and many countries in Asia and Europe. Today Xian is the largest city in northwest China and the political, economic and leading cultural center of the Shaanxi Province. During your two-night stay in this interesting city, enjoy comfortable, air-conditioned guest rooms at the modern **Xian Hyatt Hotel**.

See the famous terra-cotta warriors — nearly 7,000 life-size figures of soldiers and horses accidentally discovered in 1974 by a group of peasants digging an irrigation well. Among China's most significant

Itinerary

Day	
1	Depart gateway city Cross the international date line
2	Narita (Tokyo), Japan Nikko Narita Hotel
3	Shanghai, China Welcome Reception Shanghai Hilton Hotel
4	Shanghai City Sights Worker's Residential Area/Children's Palace Theatrical or Acrobatic Show
5	Jade Buddha Temple Beijing Shangri-La Hotel
6	Mao's Memorial/Tiananmen Square/Forbidden City Peking University/Summer Palace
7	Full-Day Great Wall and Ming Tombs Tour, with lunch
8	Temple of Heaven Xian Xian Hyatt Hotel
9	Terra-Cotta Warriors Xian City Sightseeing/Shaanxi Historical Museum Tang Dynasty Dinner and Show
10	Guilin Guilin City Tour Guilin Sheraton Hotel (river-view rooms)
11	Full-Day Li River Cruise, with lunch Farewell Reception
12	Reed Flute Cave Hong Kong Regal Airport Hotel
13	Return to gateway city



Enshrouded in mystery, the mountains tower above the Li River, making Guilin one of the most scenic spots in southern China.

archaeological finds, this cache of statues stands guard at the main entrance to the royal mausoleum of Qin Shi Huang-di (259-210 B.C.), the Qin Dynasty emperor who unified China and linked together segments of the Great Wall.

Marvel at the find's complexity and the attention to detail that must have been necessary to create such a feat. No two figures are alike. Each was sculpted with individual facial detail and dressed in the ornate uniform of his unit. Most stand at attention for imperial review. Others drive chariots or are poised for hand-to-hand combat.

A museum has been built to cover the dig. Other figures with chariots and horses, discovered in 1980, are protected by glass cases at two other museums.

Later, visit the Big Wild Goose Pagoda and the Bell Tower in the center of Xian. At the Shaanxi Historical Museum, see historical artifacts from the Zhou, Qin and Han periods. This is also a good recap of your visit to the terra-cotta warriors excavation site. A **Tang Dynasty Dinner and Show** rounds out your visit to Xian.

Guilin

Depart from Xian for southern China. A two-night stay in Guilin, set cozily on the banks of the Li River, offers a



A fisherman, with trained cormorants, makes his living along the shores of the Li River.

firsthand glimpse at the legends that have surrounded this peaceful corner of the world for centuries. Enjoy river-view rooms at the **Guilin Sheraton Hotel**, a new hub of excitement offering a full range of world-class services and deluxe amenities.

View some of the region's most mysterious and historical aspects on a city tour of Guilin, founded in 214 B.C. See the city's major sights, including the region's dramatic and spectacular caves. Time at leisure also allows you to explore on your own, getting to know rural China and her people.

The next day, observe daily life along the shores. Float lazily down the Li River. The lush rice fields and the peculiar limestone formations, mirrored perfectly in the river waters, create a picture-perfect vision. You may even witness an unusual custom practiced by local fishermen — trained cormorants dive into the water, capture fish in their beaks and return to the boat with the catch of the day! During your stay, also visit the renowned Reed Flute Cave — an amazing sight.

At a **Farewell Reception**, reminisce with new friends about your travel adventures through China.

Hong Kong

For a peaceful night's rest before your return flight home, the **Regal Airport Hotel** offers comfort and convenience.

Arrive in China Rested and Relaxed

Your transpacific Japan Airlines flight to China is made more comfortable with a one-night stopover in Narita, Japan (just outside Tokyo). Spend a relaxing evening at **Hotel Nikko Narita**, a pleasant Western-style airport hotel; dinner and breakfast are included as part of the stay. After a good night's sleep, wake refreshed, ready to embark upon your journey of discovery through China. This exclusive opportunity is only available to passengers traveling on INTRAV group flights.

Hong Kong Two-Night Optional Extension

On an optional extension to remarkable Hong Kong, see around one of the world's most beautiful harbors, see the ever-changing spectacle of this skyscraper city. With the end of British rule in 1997, its history is being written with each passing day — well worth a visit, or return visit, in 1995.

A ride on the Star Ferry, incomparable bargains in the colorful markets, and the floating city of Aberdeen are good reasons to highlight Hong Kong. The food is among the best you'll find anywhere, while the lingering debate is whether the view from Victoria Peak is better in the daylight or at night; by night, the lights of the city shine like pearls at your feet.

During your stay, enjoy harbor-view accommodations at the deluxe Conrad Hong Kong Hotel, complete with exclusive Concierge service at the INTRAV Hospitality Desk. Spend the final night of your China Adventure, plus two extension nights, in luxurious comfort.



Junks and sampans cruise Hong Kong Harbor:

American breakfast is included daily. Plus, an included Hong Kong Island Tour enhances your visit to this intriguing city. All airport/hotel transfers also are included.

\$539 per person, double occupancy

\$989 single occupancy



Hong Kong lights up at night.

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DEPOSITS: Deposits paid by tour participants indicate acceptance of the above terms and conditions. Final payment for all tours is due 70 days prior to the departure date. Credit cards cannot be accepted for final payment. All cancellations, for any reason whatsoever, will be subject to a \$100 per person administrative fee. In addition, cancellations within 70 days prior to departure are subject to a \$1,000 cancellation fee per tour participant, unless the accommodations can be resold. Domestic airfares are subject to the applicable airline cancellation fees, are subject to change without notice and are not included in the trip cancellation fee above. All cancellations or claims for refund must be submitted in writing to INTRAV.

Here's How to Reserve Your China Adventure:

Send to: **Colorado Medical Society**
c/o INTRAV
7711 Bonhomme Avenue
St. Louis, MO 63105-1961

Enclosed is my deposit of \$_____ (\$500 per person) for the China Adventure.
I understand that reservations must be paid in full 70 days prior to departure.

Name _____
Last (as it appears on your passport) Title First Initial

Name _____
Last (as it appears on your passport) Title First Initial

Home Address _____

City _____ State _____ Zip _____

Area Code _____ Home Phone _____ Office Phone _____

- ☐ Enclosed is my deposit check, made payable to INTRAV.
☐ Charge my deposit to:
☐  ☐  ☐  ☐ 

Card # _____

Expiration Date _____ / _____

Signature (as it appears on your card)

Please make domestic round-trip flight reservations (at additional cost of airfare) to Los Angeles from _____

(Departure City)

- ☐ Do not make domestic flight arrangements.
On international flights, I prefer:
☐ Smoking ☐ Nonsmoking.

Hong Kong Two-Night Optional Extension

- ☐ \$539 per person, double occupancy
☐ \$989 single occupancy

✂ ----- For Reservations Call **1-800-456-0020**. Your Reservation Code Is: **07004-CA95-09/30** -----

\$3999 per person, double occupancy,
from Los Angeles

Single Supplement: \$650

Departure Fees: \$38

At your request, INTRAV will make your round-trip flight arrangements to Los Angeles. Sample round-trip airfare effective January 15, 1995:

Denver \$435

Airfares from other departure cities available upon request. **Indicate your departure city on the coupon.** The fare will be reflected on your final invoice.

After You Reserve... INTRAV provides complete pre-departure and destination information services.

Through a series of pre-departure mailings, we will provide sightseeing, climate and weather information, clothing and packing suggestions, and quick facts.

Toll-Free Number... we are only a phone call away. Passenger Service representatives will gladly assist with questions large and small.

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- Round-trip scheduled flights from the gateway city via Japan Airlines
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- Experienced INTRAV Travel Director
- **All sightseeing is included**

Shanghai

- Two nights at the **Shanghai Hilton Hotel**
- American breakfast daily
- Welcome Reception
- Shanghai City Sightseeing
- Worker's Residential Area/Children's Palace
- Theatrical or Acrobatic Show (subject to availability)
- Jade Buddha Temple Visit

Beijing

- Three nights at the **Shangri-La Hotel**
- American breakfast daily
- Mao's Memorial/Tiananmen Square/Forbidden City
- Peking University/Summer Palace

- Full-Day Great Wall and Ming Tombs Tour, with lunch at the Beijing Golf Club
- Temple of Heaven Visit

Xian

- Two nights at the modern **Xian Hyatt Hotel**
- American breakfast daily
- Terra-Cotta Warriors
- Xian City Sights/Shaanxi Historical Museum
- Tang Dynasty Dinner and Show

Guilin

- Two nights at **Guilin Sheraton Hotel** (river-view rooms)
- American breakfast daily
- Guilin City Tour
- Full-Day Li River Cruise, with lunch
- Reed Flute Cave
- Farewell Reception

Hong Kong

- One night at the **Regal Airport Hotel**
- American breakfast

Hong Kong Two-Night Optional Extension

- Accommodations at the Conrad Hong Kong Hotel — harbor-view rooms

(three nights — final program night plus two extension nights)

- American breakfast daily
- Hong Kong Island Tour
- Exclusive Concierge service at INTRAV Hospitality Desk

Plus, Many Extras

- Exclusive Concierge service at INTRAV Hospitality Desks throughout China
- All overseas airport/hotel transfers with the group, including tips to porters for luggage handling
- Deluxe travel bag
- Deluxe passport wallet and engraved name badge
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- Automatic \$250,000 Flight Insurance Policy for each INTRAV-ticketed passenger, subject to policy terms and limitations

Optional insurance coverage for Baggage, Accident and Trip Cancellation/Interruption is available at special low-cost group rates.



Denver surgeon elected to AAOS Board of Councilors



Harold A. Yocum, MD

Denver Orthopedic Surgeon Harold (Hal) Yocum was elected in January to the Board of Councilors of the American

Academy of Orthopaedic Surgeons. He succeeds John O. Cletcher, M.D., of Longmont, Colorado. Cletcher is a current member of the Colorado Medical Society Board of Directors.

Dr. Yocum is Immediate Past President of the Clear Creek Valley Medical Society and a former President of the Colorado Orthopaedic Society (COS) and a current member of the COS Board of Directors. He has been a member of the CMS Workers' Compensation Committee since 1989, served on the State of Colorado Workers' Compensation Cost Containment Task Force and is an instructor for the Level II Accreditation for Workers' Compensation. Hal Yocum has been involved extensively in workers' compensation practice for the past decade.

He has been a member of the Colorado Medical Political Action Committee (COMPAC) since 1990 and served on the CMS Task Force

for Physician Network in 1993 and 1994.

Dr. Yocum received his Degree of Medicine from the Jefferson Medical College in Philadelphia. He entered the U. S. Army Medical Corps Reserve in 1968 and then went on active duty in 1970 for 11 years, continuing with reserve service until his retirement in 1992. He is a current member of the American Medical Association and has been an active member of the Colorado Medical Society since 1981, holding many . His practice subspecialty is hand surgery.

CopicComment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Professional liability insurance in the future

A question recently asked of COPIC — do we see liability shifting from individual physicians to the large companies and medical groups, since such organizations may have "deeper pockets"?

First, Colorado is one of three states left without the corporate practice of medicine, therefore, this shift will be a slower evolution in Colorado.

Secondly, COPIC works "hand in hand" with our managed care

organizations in a positive manner to minimize problems between their practicing physicians and the organizations.

Thirdly, COPIC has worked through its policyholder service division to create proper relationships among the individual physicians and the large medical groups with whom service personnel associate. We encourage quota-share programs so that enhanced risk management programs are in

place at these organizations which have as their goal to decrease, not increase, the liability of not only the individual physicians but that of the large companies and medical groups.

Finally, COPIC will not just watch but participate in the evolutionary process of consolidation and vertical integration of their physicians within the health care systems to minimize the targets for the trial lawyers.



AMA, CDC offer Packet on Immunization Practices

The American Medical Association, working with the Centers for Disease Control and Prevention, has developed an educational packet on immunizations which is now available to physicians.

The packet, entitled "Make Sure They're Covered", contains information on:

- The Vaccines for Children program.
- The updated recommended immunization schedule (as of January, 1995).
- Standards for Pediatric Immunization Practices.
- Vaccines in development.
- Vaccines for older adults.
- Vaccines for immunocompromised patients.
- The National Vaccine Injury Compensation Program.

Also included is the CDC "Guide to Contraindications to Childhood Vaccinations," as well as additional references and useful phone numbers. All of the project's expenses are funded through a grant from the CDC.

The kits are available free by calling 800-621-8335 and requesting product number NC015895. The kit includes a toll-free number for follow-up calls.

How much are medical managers paid?

A survey published by the American College of Physician Executives provides profile information on the participants. While there were wide variations in the actual survey participants base, the typical survey respondent was a Medical Director in a hospital who spends between 75 and 100 percent of his or her time in management, does not have a management degree, is satisfied with his/her management role, and plans to stay in management rather than return to clinical practice.

Here are some highlights of the survey results:

The median 1994 total compensation (salary plus bonus and incentive) for participants who spend 100% of their time in management was \$166,000.

The median 1994 total compensation for all survey participants for management activities was \$145,000, with the average time spent in management at 71 percent.

The highest paying organizations in rank order are health care systems, followed by managed care organizations, private industry, academic health care, hospitals, and integrated medical groups. IPA's are the lowest payer.

Calculated Risk: New AHA Publication

Calculated Risk, a new American Hospital Association publication by the actuarial and consulting firm Milliman & Robertson, Inc., helps providers examine the nature of the financial risk involved in managed care arrangements (including capitation) and the analytical, financial, clinical, and administrative tools they can use to evaluate their ability to assume and manage that risk.

For information locally, call Jay Mildenerberger, Milliman & Robertson, 303-672-9016. *Calculated Risk: a Provider's Guide to Assessing and Controlling the Financial Risk of Managed Care*, Catalog no. D1-131001, can be ordered from American Hospital Association.

CHAMPUS to begin HMO style operation

With the Defense Department's recent announcement of the costs to patients of its new HMO-type TRICARE Prime health benefit option, service families will be able to determine how much they'll pay — and how much they'll save — when getting care under "Prime."

TRICARE, Defense's regional managed-care program, will go into effect nationwide, in 12 regions over the next several years. The first



region to have a TRICARE managed-care support contract in operation will be region 11, which includes the states of Washington and Oregon, beginning this month.

Under the TRICARE Prime voluntary enrollment option, families will receive their health care from a network of civilian and military providers. There's no enrollment fee for active-duty families; for other CHAMPUS -eligible persons, the annual enrollment fee will be \$230 for an individual and \$460 for a family. Patients treated in service hospitals will continue to receive care in those facilities without having to share in the cost of the services provided.

The Defense Department estimates that enrollment in TRICARE Prime could save the enrolled active-duty E-4 and-below family an average of \$170 on its health care costs each year. The estimated annual savings for other active-duty families is \$240. Military retirees, survivors and their families could save about \$100 per year, according to the Defense estimate.

A second option, TRICARE Extra, won't require enrollment. CHAMPUS -eligible persons will be able to use the "Extra" program's preferred network providers on a case-by-case basis, with discounts on cost-sharing and usually no claims to file.

The third option, TRICARE Standard, is the same as the standard CHAMPUS program. Patients may use any CHAMPUS-authorized providers they choose, and will be subject to regular cost-sharing amounts and annual outpatient

deductibles.

CHAMPUS-eligible families will receive information about their region's TRICARE managed-care support program in the near future.

Call for Poster Session Abstracts

The National Council on Patient Information and Education (NCPIE), announces a "Call for Poster Session Abstracts" for the 10th National Conference on Prescription Medicine Information and Education, "Integrating the Art and Science of Prescription Medicine Compliance," May 8-9, 1995 at the Sheraton Washington Hotel in Washington, D.C.

You may request "Guidelines for Submitting a Poster Session Abstract" by: 1) calling NCPIE at (202) 347-6711; 2) faxing a request to NCPIE at (202) 638-0773, and 3) writing to NCPIE c/o: NCPIE Poster Guidelines, 666 11th Street, # 810, Washington, D.C. 20001.

Warning to parents: "Don't put your baby to sleep on top of soft bedding".

A study conducted by the U.S. Consumer Product Safety Commission (CPSC) has determined that unsafe use of soft bedding may contribute to the deaths of as many as 1,800 infants each year.

The two-year study conducted by the U.S. CPSC found that up to

30% of the 6,000 babies who die of Sudden Infant Death Syndrome each year may have suffocated to death when placed on top of pillows, comforters, sheepskins, and other soft products.

"It is important to note that there is still no known cause of SIDS" said Roger Holbrook of the Consumer Protection Division.

A team of CPSC investigators found that about 30% of infants who died of SIDS between 1992 and 1993 were found with their noses and mouths covered by soft bedding. Most of those infants had been placed on their stomachs to sleep and were lying either on top of the sheepskin bedding, on top of pillows, or on top of comforters.

Colorado Department of Public Health and Environment recommends the following safety guidelines for infants less than eight months old:

- Place infants to sleep in cribs on a firm mattress.
- Do not place soft, fluffy products, such as pillows, comforters, or sheepskins under infants while they sleep or nap.
- Place healthy infants on their backs or sides to sleep, as recommended by the American Academy of Pediatrics.



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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

Denver's not really a "cow- town;" it's a loose collection of "Fields of Dreams".

I can't believe anyone who has lived in Denver at least two years doesn't know everything about major league baseball coming to town, about Coors Field, about the players' strike, about the impact of no baseball in a baseball town. You just can't help but know these things, when it's all re-washed and hung out to dry every day. You can't pick up a newspaper, turn on the radio or television without being hit (no pun intended) with at least one aspect of the subject . . . any day!



Photo: Bill Pierson-CMS 2/95

People know more about major league baseball, player negotiations, batting records, earned run averages, everything from the sandlot to the present time, than they do about **their own health care**. It's a line we've dutifully swallowed for soooo many years: not to know or love baseball is like not teaching a little boy that it is unmanly to cry.

Denver was once noted for a quality of life rather than the "great city" facets of today's mega-sports attractions. It's amazing how, in

decades past, Denver and Colorado became noted for the healthy environs; Denver was a center for treatment of and recuperation from respiratory and consumptive illness (JCRS, NJH, Agnes Phipps Sanatorium, the Glockner Tuberculosis Sanatorium in Colorado Springs).

Where are we when it comes to health care? Health insurance? Managed care? What do these things actually mean to us as individuals? If each of us knew what each insurance health care plan held for us in times of need, we might have a bargaining chip. If we could read an insurance policy like we read an outfielder's stats we might be able to see what's coming down the road in our own health care. If we could ask for and read a profit/loss statement from some of the managed care firms which have sprung up, we might be able to understand the motivation and the tremendous differential between quality of care and cost of care in today's health industry coalitions.

Certainly, the sport of baseball has a great dissimilarity to practice of medicine. It is the hugeness of the dissimilarity that makes their juxtaposition so interesting.

- Physicians talk about fees and they will surely be brought up on anti-trust charges. Baseball is immune to antitrust.
- Physicians try to form a union to negotiate fees and work conditions and (you guessed it) the public and the courts come unglued; Baseball players and owners alike form their own unions and hold hostage a gullible public stuck with their expensive season tickets.

- The public votes to use public tax monies to underwrite private business to build a baseball stadium; Colorado's physicians are still doing a lot of medical service free because it **costs** them more if they charge for the Medicaid services than if they just don't even file for reimbursement.
- Since before the turn of the century, Colorado physicians have an unmistakable record of battling air pollution; in one fell swoop, baseball has put metropolitan Denver back at least thirty years by building the largest, most powerful auto pollution magnets into the heart of the Platte River Valley.

Nothing in the past fifty years has had the pollution impact that Coors Stadium will have, drawing more cars into the Valley at one time than even the workaday downtown traffic we profess to be trying to cut. And to top it off, Denver's magnificent new 'light rail' doesn't run anywhere near the Stadium to encourage any pollution-free public transit. Attracting this number of vehicles into the downtown area will do more harm to Denver's air than if we went back (fifty years) to coal burning and the Black Cloud.

Of course, another tremendous change to the Valley is the move of Elitch Gardens, which will attract still more autos and people. After the flood of 1965, laws prohibited anyone from building in the valley, in the flood plain. We didn't consider that in the Cherry Creek flood 130 years ago; now, we're talking about building along the Platte River **today**.

RUMINATIONS (Continued)

It was only four short city blocks (less than half a mile) from the new main entrance to Elitch Gardens that the photo (below) was taken of the flood of 1864. I guess changing the laws about flood plains helps get things done. The cover photo of the new Elitch Gardens and its tower was taken just 13 weeks before the park's



Photo: Denver Planning Commission; "Denver Planning Primer, 1940"

Isn't it interesting that this "backwater cow town" has suddenly burgeoned into a "great city" because of its hunger and thirst for major league sports.

Yes, Denver certainly fits the "Field of Dreams" mold... football, baseball, basketball, hockey, world's largest air terminal, among the largest convention centers, newest amusement park ... let's build these things to fit the mold, then we can "imagine (we have) a great city".

And through it all, in some way, Denver seems to have kept its "cow-town" image: Denver is still the collection of the largest number of health maintenance organizations and managed care plans, per capita, second only to Minnesota. That means Denver still has the

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attraction of being one of the biggest discount stores in the country. "Try it first in Denver; they love 'brand names' and 'major leaguers.' They have a great affinity for 'team jackets.' And if you can't sell it in Denver, it won't sell anywhere." Medicine today is sort of like major league baseball today: there are owners and there are players. But in medicine, it's whoever owns the patients versus the players (physicians). The dissimilarity though is the doctor can't bargain; he can't join with other doctors to argue the rules of play or even of participation. If he doesn't own the patients, he doesn't have any choice about how he will practice medicine. Someone is going



Denver Municipal Airport (circa mid-1930s)

Photo: Bill Pierson collection

RUMINATIONS (Continued)

to tell him, and there's no such thing as a "free agent", and if the owners want a "cap" on salaries or player recompense, the player has nothing to say about it. In medicine, the players can't strike if they wanted to. In the early days of "Denverhood", the times of the stage coaches and horse and buggy, medicine shows were quite popular. I often think that the medicine show is still going strong.

In the earliest days of aviation, the Denver Airport was located at East 36th and Dahlia (prior to Stapleton Field), on what is now Park Hill Golf Course. About the last medical connection with that airport was that some of the buildings were still occupied into the 1970s, but as a warehouse and distribution center



What was once Denver Municipal Airport and "Combs Field" at E. 38th and Dahlia. Sign on hangar says "Combs Aircraft Company", forerunner of AMR Combs, founded by Harry Combs, a Denver aviation pioneer.

for the A. S. Aloe Medical Equipment Company. At least one of the buildings, a hangar and operations office bearing the names of another aviation pioneer, "Combs Aircraft

Company", is still there, and that's where it all started in the long trek to DIA. Stapleton Field was one of the first "Fields of Dreams" created by bureaucrats to put Denver into the transportation mainstream. It wasn't even necessary to have paved runways, etc. Union Pacific Railroad had decided that Cheyenne, Wyoming, was going to be the jumping-off place for transcontinental travel, sidestepping Denver. No matter; Mayor Ben Stap-

leton's namesake served all Colorado and the Rocky Mountain West/Western Great Plains extremely well, right up until its last day (presumably February 28, 1995) almost 70 years later.

Another one of those great projects (and this one was, in fact, inspired by Mayor Stapleton) was the Denver City and County Building.

The Mayor's office commissioned four or so architects to design and construct the building. Fred Bonfils, of the Denver Post Bonfils & Tammen, didn't want to see that building built. I'll skip all the details. Well, Bonfils went into the law books and found a little-used statute which said that professionals could not form a consortium for such work, and the job was halted because it was illegal for the county to pay such a professional consortium (does this sound like a possible antitrust case coming up?). The Mayor couldn't pay for the project, so the construction stopped at about the second floor level.

But Mayor Ben appointed a "City Architect" and the money was appropriated out of county funds to finish the project. If you can't identify the style ... well, the design started with four architects, but a fifth came by and finished the job. In any event, the project was only stalled by less than a year. Speaking of "**Fields of Dreams**", how 'bout that DIA, give or take a billion or so dollars and a year or two overrun?

I am assuming that by the time you read this, Denver International Airport will have opened for business. Build it and they'll come.



February 21, 1932, as Denver FreeMasons conduct a ceremony laying the cornerstone of Denver's City and County Building. Photo from the Harry Rhoads Collection. Courtesy of Morey Engle.

“Your Doctor Will See You Now, Ms. Smith.”

How important is the relationship between patients and their physicians? The Colorado Medical Society stands with you in preserving a patient's right to choose a physician.

COMPAC, the political arm of the Colorado Medical Society, is working day in and day out to make sure patients continue to have their choice of physician — instead of having one chosen for them. And that's why CMS has introduced HB 1262, which would make patient choice the law in Colorado.

COMPAC is sending our legislators the message that physicians will stand up for the rights of patients. Let your state representative know that patients should have a choice in who maintains their health and the health of their families. Call your legislator and ask him or her to vote for HB 1262, today. (House of Representatives 866-2904, Senate 866-2316)

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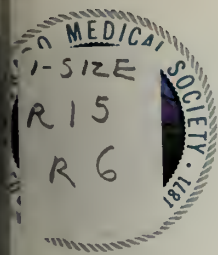
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il, 1995

Volume 92, Number 4

"Alpine Adventure"



Innsbruck, Austria, 7:15 am, Saturday - fog and mist - just another sleepy European town at the foot of the Tyrolean Alps. See "Member Services" news on page 149.

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You spent over
8 years in school,
over 300 all-nighters studying,
4 years in residency,
countless years working 7 days a week,
thousands of hours on call,
who knows how much in tuition,
and an unspeakable amount
in student loans.

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COLORADO MEDICINE

April, 1995

Volume 92, Number 4



Cover Story

Experience the glory of waking up on a foggy morning in Innsbruck. See page 149 for details.

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CMS Med Fax[®]
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

Crossing the Line

Physicians with Sexual Boundary Problems

The Colorado Physician Health Program will hold its ninth annual meeting on April 28, featuring Michael H. Gendel, MD on the topic: *Crossing the Line: Physicians with Sexual Boundary Problems*. According to CPHP, physicians who engage in social and/or sexual relationships with patients cross a professional boundary. This can include contact with patients and/or harassment of employees or colleagues. Dr. Gendel will define sexual harassment and misconduct, as well as describe reactions of victims and evaluate physicians who present with such behaviors. Issues of cause (including illness), treatability and workability will be discussed.

The meeting will also include a panel discussion of regulatory issues such as BME handling of sexual misconduct complaints, legal considerations in the handling of sexual harassment and sexual misconduct complaints, experiences treating victims of sexual harassment and sexual misconduct and the experience of treating the physician with boundary problems.

This Friday afternoon program begins with a luncheon address by CPHP Board President Frederick R. Paquette, MD. For more information, contact CPHP at 303-860-0122 or 1-800-927-0122.

ACCME Secretary/Executive Director Appointed

Murray L. Kopelow, M.D., has been named the first full-time Secretary/Executive Director of the Accreditation Council for Continuing Medical Education (ACCME). Dr. Kopelow has been active in the development of programs to assess professional competence. He has also worked on developing standardized patient examinations and evaluation tools for medical schools and credentialing organizations in both Canada and the United States.

ACCME Chairperson, James A. Hallock, M.D., announced this appointment stating: "The ACCME is

delighted to have recruited a person of the caliber of Dr. Kopelow to serve as its Secretary/Executive Director. I am sure that he will be a catalyst in moving the Council forward with its agenda and goals."

The ACCME is a not-for-profit agency established in 1981 which accredits over 500 national sponsors of continuing medical education and oversees recognition of state and territorial organizations (including the Colorado Medical Society) which accredit 1,900+ intrastate sponsors.



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate
with the law firm of Montgomery Little &
McGrew, PC.

*This column is not legal advice, but is
for general information only. For help with specific problems,
readers should consult an attorney.*

OBRA 1993 & Stark II

by Michael H. Smith, Montgomery Little & McGrew, PC
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More Exceptions...

(continued from last month)

Physician Services

Under what has come to be referred to as the "group practice exception," Stark II does not prohibit a referral for physician services that are provided personally or under the personal supervision of another physician in the same group practice as the referring physician. Not surprisingly, the statute contains a lengthy and detailed definition of the term "group practice." For purposes of this article, suffice it to say that a group practice requires at least two physicians legally organized in an associational form such as a partnership, professional corporation or foundation.

The group members must essentially conduct their practices through the group, bill in the name of the group, and share overhead and revenues of the group. Group members may not, directly or indirectly, receive compensation based on the volume or value of referrals, although physicians may be paid a share of overall profits of the group or a productivity bonus as long as the share or bonus is not based on the volume or value of referrals by such physician. In addition, members of the group must personally conduct no less than 75 percent of the physician-patient encounters of the group practice. Finally, the statute authorizes the Secretary of Health and Human Services ("HHS") to impose additional requirements by regulation.

The group practice exception is curious in that it applies to referrals for "physician services", notwithstanding that such services are not listed among the designated health services included under Stark II. That issue aside, it appears that Stark II permits physician referrals for designated health services within a "clinic without walls," assuming the shared overhead and income criteria, among the other criteria, are satisfied. The exception may be applied even if the individual office sites have as few as one physician - a departure from earlier versions of the bill, which would have required five or more physicians at each site.

The group practice exception is not vitiated simply because the group contracts with physician specialists outside the group on a periodic basis and bills for these services (to the extent otherwise permissible under applicable third-party payer rules) in the name of the

group. However, this is not to say that referrals can be made outside the group for the provision of designated health services if the referring physician has a financial relationship with the recipient of the referral, unless some other exception is satisfied.

Similarly, contracts with temporary replacement physicians will not generally interfere with the group practice exception as long as the criteria are met. In both cases, however, if the statutory prohibition is otherwise implicated, the group will have to show that 75 percent of physician-patient encounters is conducted by members of the group, a standard that is undefined and can be measured in a multitude of ways.

In-Office Ancillary Services

Referrals for in-office ancillary services continue to be permitted under Stark II, provided a three-prong statutory test concerning the provider, location and billing services is met. The in-office ancillary service exception does not apply to DME (other than infusion pumps) or to parenteral and enteral nutrients, equipment and supplies.

Under the first prong of the test, services must be furnished personally by (1) the referring physician, (2) a physician in the same group practice or (3) an individual who is directly supervised by the physician or by another physician or by another physician in the group. The second part of the test requires that in-office services must be performed either in a building where the referring physician (or another physician in the same group practice) furnishes physicians' services unrelated to the furnishing of designated health services or, if in a group practice setting, in another building used by the group under certain specified circumstances. Under the third criteria, services must be billed by the physician performing or supervising the service, by the physician's group practice under the group's billing number or by an entity that is wholly owned by such physician or group practice.

The definition of group practice for purposes of the in-office ancillary service exception is the same as that discussed above for the physician service exception. However, no definition is provided for the term "directly supervised by." Presumably, because services must be billed by the supervising physician or his or her group for the exception to apply, the individual being supervised will be an employee of the supervising physician or of the group.

Prepaid Plans

A general exemption is granted for designated health services furnished by an organization such as a Medicare contracting HMO or a Competitive Medical Plan.

Other Financial Arrangements

Stark II expressly authorizes the Secretary of HHS to adopt regulations exempting other financial relationships from the statutory prohibitions if the Secretary finds such relationships do not pose a risk of program or patient abuse. It is likely that the development of additional regulatory exceptions will proceed in tandem with the promulgation of any new safe harbors under the Anti-Kickback Statute, notwithstanding the differences between the two statutory provisions.

Next Month: More Exceptions...

Own a piece of personal history

Limited edition lithograph of *your* medical school

In 1965, the Squibb Pharmaceutical Company commissioned a series of paintings of all the medical schools in the country. In honor of their founder, Dr. E. R. Squibb, the first painting was of Jefferson Medical College in Philadelphia, of which Dr. Squibb was an alumnus.

Mr. Jack Klotz of Englewood, Colorado was a sales representative for the company in those years and obtained a set of the lithographs of these paintings which were presented to alumni of the various medical schools. Mr. Klotz, now retired, has made these unique works of art available to the Colorado Medical Society.

Mr. Klotz's collection contains lithographs of paintings of thirty different medical schools. He has asked us to distribute them to interested alumni of the schools who did not have the opportunity to obtain them in 1965. If your school is listed below, you may obtain the copy of the painting of your school at no charge, on a first-come, first-served basis.

If you desire to obtain this fine art print, or need further information, please contact Bill Pierson, Director of Communications and Member Services, Colorado Medical Society, 303-779-5455 or 1-800-654-5653.



Jefferson Medical College of Philadelphia

Here are the schools in this collection:

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Texas
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Women's Medical College of
Pennsylvania
Minnesota

State University of NY Downstate
Tufts
Tennessee
New York University
Tulane
Michigan
University of Pennsylvania
Northwestern
Medical College of Virginia
Wayne State
Johns Hopkins
Iowa
Loma Linda

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Advisory Council on Health Programs for Women and Children

Regular monthly meeting.

For information call Suzette Clark at (303) 692-2421.

University of Colorado at Denver

The Ethics of Managed Health Care

April 1, 2, 7, 14, 21, 28 & May 5th

Contact Jill Rulon or Erica Reno at (303) 820-5600.

University of Colorado Sports Medicine

The Female Athlete: Enhancing Health and Fitness

April 7, 1995

Stapleton Plaza Hotel

Denver, CO

Contact: 800-882-9153 or (303) 372-9050

Colorado Department of Public Health and Environment

"Advisory Council on Health Programs for Women and Children"

April 19, 1995

Contact: Suzette Clark at (303) 692-2421.

Medical Group Management Association

Spring Meeting- "Mid-Level Providers: Extending Services, Expanding Revenue, Avoiding Pitfalls"

April 20, 1995

Denver, CO.

The Inverness Hotel (Formerly The Scanticon)

Contact: (303) 397-7881

The 8th Annual Penrose-St. Francis Trauma Symposium

"Trauma, the 20th Century Epidemic: Continuity and Communication"

April 28, 1995

Colorado Springs, CO.- Red Lion Hotel

Contact: (719) 776-5926

National Jewish Center for Immunology and Respiratory Medicine & the Horticultural Therapy program of the Denver Botanic Gardens

"Gardening for Life"

May 1, 1995

Contact: 370-8020

Colorado Health Services Marketing

"Integration: Market Forces and Critical Success Factors"

Friday, May 19, 1995

Denver, CO.

Marriott Denver Tech Center

Contact: Fontera & Assoc. at (303) 674-5269

Colorado Society of Osteopathic Medicine

Annual Meeting

June 16-18, 1995

Snowmass Conference Center, Snowmass at Aspen, Colorado

Contact: Patricia Ellis (303) 322-1752

American College of Cardiology

Echocardiographic Symposium of 2-D and Doppler

Echocardiography at Vail

July 31-August 3, 1995

Marriott's Vail Mountain Resort, Vail, Colorado

CME credits: 23 Category 1 AMA

Contact: 800-257-4739, FAX 301-897-9745

International Meniere's Disease Research Institute

8th Annual Electrocochleography/Otoacoustic Emissions/Intraoperative Monitoring Seminar, August 2-6, 1995 Denver, CO.

Contact: Jane Wells or I. Kaufman Arenberg,

MD.(303)778-4235

American Association of Blood Banks

Ensuring a Predictable Donor Base: Marketing Models for the 21ST Century

September 10-12, 1995

Hyatt Regency Denver, Denver, CO.

Contact: (303) 295-1234



PRESIDENT'S LETTER



David C. Martz, MD
President, 1994-1995

If not ME, who? If not NOW, when?

These are the words that echoed in my soul some 18 months ago when members of the House of Delegates offered me the opportunity and responsibility to become your President this year. And now, 6 months into that role, the words continue to confront me every day: If not me, who? If not now, when?

Today, I stand before you to share with you the meaning of those words and these months in the hopes that you will make them your own.

For those of you who may wish to consider this duty for yourself — as well as those who are content with vicarious insight — the realities of becoming CMS President are indeed life-changing.

But I LIKE the job you have given me. . . I survive because:

1. My wife is fully supportive and 100% self-sufficient during this time when she must share me with so many others;
2. I can function pretty normally on 5 hours of sleep a night—and get by for a few days on only 4; and
3. I get a lot of gratification from what we are doing.

I can not mention each name and each job that deserves credit, but I can say it is the people and their attitudes that fuel my fire and keep me going. Everyone is really great!

Well. . . nearly everyone. I must admit that there are occasional times when the rule of 98 and 2 catches up with me; that is, 98% of the angina is precipitated by 2% of the colleagues! But we are by nature a varied and opinionated group, and often it is the outspoken and creative thinker who prods us to new and important perspectives—so, conventional or not, my door is open and my phone on the hook to respond to your two-fisted issues.

Yes, I LOVE being your President—your coach and cheerleader, the facilitator of teamwork that utilizes YOUR knowledge and YOUR skills.

But what have we accomplished in these 6 months? Well, we have responded to each of the priorities you designated at last year's Planning conference in Vail:

Priority Number One: Coalition building, and we have pursued that vigorously and with excellent response. . .

a. The rift between the Colorado Academy of Family Physicians and CMS—oceanic in its proportions historically—is now only a handshake away. We now sit at the same table, attend each other's retreats, and testify in harmony at the legislature. A new trust and respect has laid the groundwork for ongoing dialogue about other issues of mutual concern in the days ahead.

b. The Coalition of Physicians (COPS) meets every month or two and brings together the physician leaders of the Colorado specialty societies to share our concerns, align our goals, and coordinate our efforts.

c. The Provider Coalition is made up

of the lobbyists of:

CMS

Colorado Society of Osteopathic Medicine

Colorado Psychological Association

Colorado Dental Association

Colorado Physical Therapy Association

Colorado Rehabilitation Coalition

Colorado Optometric Association

Colorado Podiatric Medicine

Association, AND.

Colorado Chiropractic Association.

This conglomeration of previously strange bedfellows has agreed to disagree on many issues, but to work together when mutually beneficial. Credit this group for killing the bill to raise your license fees to lower the cost of midwives fees as well as SB 45 which would have made it nearly impossible to legislate future health care mandates!

d. The Colorado Hospital Association is now meeting at the same table with CMS to work out issues of mutual concern including the Corporate Practice of Medicine bill, Data Commission issues, and, hopefully, cooperation with our Point of Service (POS) initiative;

e. We are meeting regularly with the HMO Association and have made history by negotiating a White Paper outlining new precepts of fairness in affiliation-disaffiliation issues. It is our hope and belief that this is just the beginning of ongoing dialogue and mutual problem-solving.

f. Copic and CMS have entered a new level of communication with Dr. Jerry Buckley (Copic CEO) and myself meeting regularly, as well as representing our respective organiza-

(Continued on following page)

tions at the other's board meetings.

Priority Number Two: Pro-active legislation. We have worked hard to establish credibility, consistency, contacts and negotiation skills at the capitol, and it appears to be paying off. Furthermore, Dr. Richard Allen, Dr. Joel Karlin and I are embarking on a 2 year plan that will include:

1. Establishment of personal relationships with both the legislative and executive branches;
2. Grass roots support of citizens and organizations throughout the state; and
3. Analysis of what might be accomplished THIS year, NEXT year, and the year after.

In addition to the PRO-active efforts, we have sought to protect the best interests of Coloradans and physicians by:

1. Highly effective handling of the Medical Practice Act, due largely to the efforts of Dr. Steve Thorson and his committee—it sailed through without a blemish!
2. Opposition to expanded scope of practice into medical arenas by the naturopaths, acupuncturists, and possibly the optometrists who may introduce a late bill to allow laser surgery;
3. The previously mentioned licensure fee cap and Access to Health Care Mandate legislation which were killed by the Providers Coalition efforts;
4. The Corporate Practice of Medicine bill which was killed in committee because it did not comply with the CMS policy guidelines which we had negotiated; these guidelines have now been inserted and it will be reintroduced as a late bill;
5. The highly complex Nurse Practice Act which has consumed hours of our time at the staff, task force, legislative council, executive committee, board, and presidential levels. If any issue made me rethink my willingness to serve you, this came the closest!!

Although not perfect, it is our belief that we have achieved our goal of allowing collaborative

practice without creating independent practice—including BME oversight—but each physician must share the responsibility of establishing effective collaborative agreements.

Our third priority was to respond to the presence of Managed Care. In addition to the previously mentioned HMO White Paper, our major response to Managed Care Presence is the impending development of the Colorado Physician's Network. Suffice it to say that over 1400 members have contributed over \$143,000 to underwrite exploration of the feasibility and structure of a statewide network.

A corporation distinct from CMS has been created, a Board of Directors appointed, a consultant selected, and initial discussions about goals and core values has occurred. It is our intent to have a completed Network proposal to present by the end of May or early June.

So much for the highlights of our efforts so far. The next question is, "Where do we go from here?" We know we must recognize and admit that all our efforts have not worked out perfectly, and we must learn from our experiences and move on with greater wisdom.

We plan to focus on some additional issues in the days ahead, such as careful study of the organizational options for CMS, in keeping with the AMA Federation Consortium study of organizational modification potentials from top to bottom in an effort to meet the needs of our changing world of medicine.

I also feel it is the CMS role to reach out to meet the needs of the 1500 physicians in Colorado who have not yet joined CMS. We have had a recent dramatic growth in our Medical Student Component, and discussions are underway with UCHSC Dean Krugman to explore the possibilities of parallel professional enrollment in this time of mutual needs.

Fewer than 800 of our 5000 members are female and I will be meeting with the Women In Medicine component later this month to explore what CMS might do to better

meet their special needs.

Finally, I continue to believe that if we as physicians could truly unite in our goals and our efforts; if we could line up and march TOGETHER; if we could take the risk of innovative responses to these trying times, we could become a force beyond all dreams. . .

We could in fact again become THE leaders, THE power, THE hope of medicine in the 21st century. Let us therefore unite as a profession and as the CMS and respond affirmatively to the challenge.

Yes, 6 months into the job, I am thankful for the opportunity to be your President for a year. I share with you the challenge in your own personal and professional lives to take up the chant: "If not me, who? If not now, when?"

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society

With all my talk in the March report about walking on eggshells, it was as if the entire CMS House of Delegates and leadership had read that report and were waiting for me to dare them to become controversial about anything. . . chickens, the weather, price of eggs. . . and offend anyone. But my March report hadn't even been received by them before the 1995 Interim Meeting, March 11 and 12.

This meeting, resembling a "hail fellow - well met" reunion, was outstanding to attendees only because of how smoothly it ran. With few resolutions, we introduced an educational component to the meeting, to bring members up to date on issues currently being addressed by the Society.

The Finance Committee and the Board of Directors met on Friday, March 10 (another remarkably quiet gathering, described by some as being a "nice meeting"). The Women in Medicine Section held a business/ dinner meeting that evening, featuring a presentation on the value of humor.

The Interim, held at the Holiday Inn at I-225 and Parker Road in Denver, got under way Saturday morning. In his address, President David Martz encouraged a continuation of the momentum that has been built up through consistent efforts by the last several Presidents. He advocated personal responsibility and action on the part of all the physician leaders present.

Delegates heard an excellent detailed report on the status of Copic Insurance Company from Dr. Jerry Buckley, his first address to the

House as Copic CEO. The report was well received.

1995 CMS Alliance President Patti Brown reported on the activities of the Alliance and presented AMA-ERF checks in the amount of \$17,973.92 to Dr. Nancy Nelson of the School of Medicine. I have not checked officially, but I think this has to be a record high dollar amount for the AMA-ERF contribution. It is a reflection of the excellent work done by the 1994 CMS Alliance President Pam Laman and 1994 AMA-ERF Chair, Mary Jo Ryals.

Saturday's General Membership meeting keynoter was Dean C. Coddington, nationally recognized researcher based in Denver. Dean provided the spark of the entire meeting with his presentation on the concept and current status of Integrated Delivery Systems (IDS) in the US. He then moderated a lively panel of IDS experts at a luncheon which was very well attended.

The two reference committees finished in record time considering a total of seven resolutions, netting some discussion but little controversy. Reports, completed in short order, were discussed and acted upon Sunday morning in one of the shortest sessions of the House in recent memory.

In the "State of the Society" session Sunday, CMS leadership reported on several hot issues

(Continued on following page)

***"... continuing to tip-toe around the nest"
(more on those
"Damn chickens!").***



CMS Alliance President Patti Brown (r) presenting AMA-ERF checks in the amount of \$17,973.92 to Dr. Nancy Nelson.

EXECUTIVE DIRECTOR'S UPDATE

(Continued)

confronting members. First was the recently signed "white paper" agreement between the CMS and the Colorado HMO Association. This agreement, described by Robert D. McCartney, MD, is apparently unique nationwide. It contains concessions which are controversial in both the HMO community and among physicians.

CMS Council on Legislation Chairman Richard Allen, MD's legislative presentation included an update on current bills and activities of the CMS legislative staff, as well as a stirring speech by State Representative Pat Sullivan, MD, in which he announced his intention to run for the U.S. House of Representatives in 1996.

Dr. Karlin explained the "My Doctor. My Choice" program to encourage physicians and patients advocating that any legislation or health care industry reforms include protections for the physician-patient relationship, as well as the newly formed Patient Advisory Committee, initiated by the CMS to get patient input on health care issues.

This was followed by Dr. Martz's report on the Colorado Physician Network, Inc. (CPN), including the introduction of consultant David Ginsberg, who was chosen to help formulate the business plan for this one-of-a-kind physician-directed health care network.

And that, in an eggshell, was the 1995 Interim Meeting.

I don't know that my March Executive Director's Update is going to be well received; I do know that if ever there was a self-fulfilling prophecy any better orchestrated than this year's Interim Meeting, I sure haven't heard of it. It's almost as if everyone attending knew what I was thinking when they got there. Who knows?

Maybe it's time we break a few eggs, rather than continuing to tip-toe around the nest.

LEGAL UPDATE

*from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000*

Effective Communication Practices

Last month's Legal Update dealt with communicating effectively with insurance companies so your patient's care is uninterrupted and your bills are paid in a timely fashion. As we all know, there are times when everything is done appropriately and the bills still are not paid. What do you do?

Again, communication is the answer. Speak directly to the insurance adjuster. Follow up by writing a brief letter explaining treatment or providing information requested by the adjuster. In most instances, this step will resolve the problem.

If not, however, contact your patient and your patient's attorney, as your patient is responsible for your bills and must understand what is going on at all times. Quality personal injury attorneys will evaluate the situation and recommend a course of action. If your patient's attorney refuses to get involved, advise your patient. An unresolved PIP benefit dispute is ultimately harmful to your patient's liability claim.

Another option is to file a complaint with the Colorado Insurance Commissioner. Indicate the facts and circumstances in a short, yet complete, fashion. This can be an effective method of ensuring that the insurance company takes a good, hard look at the situation.

Obtain a second opinion from a respectable chiropractor or medical doctor. Do not pick somebody to rubber stamp your work. Pick someone who will be objective and provide him or

her all the information necessary to make an informed decision. If the second opinion confirms your treatment, provide the opinion to the insurance company. If the second opinion doesn't favor your treatment, re-think your position.

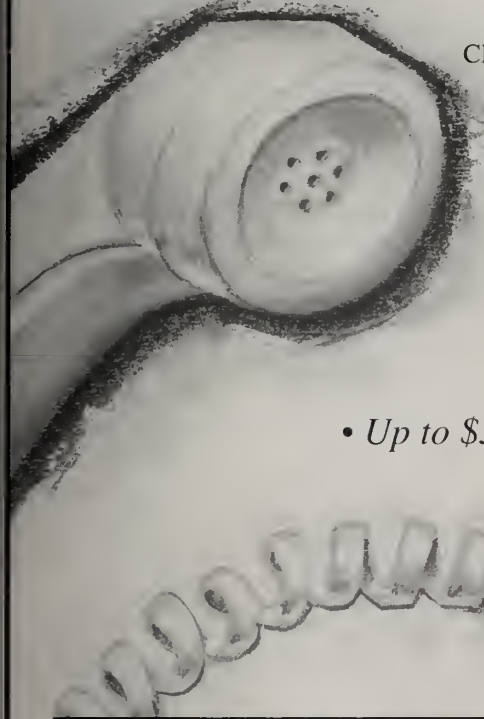
Litigation should be your final option. It is time-consuming and expensive...and can be very frustrating. The Colorado no-fault statute sets forth the procedures to follow and damages which may be recovered. C.R.S. §10-4-708 allows recovery of unpaid benefits, provides insureds with awards of attorney fees in direct proportion to the degree by which insureds are successful, eighteen percent interest on benefits and, if the withholding of benefits is deemed willful and wanton, treble damages.

By the time you have completed this process you will realize that no one wins. Both sides spend a lot of time and money to have a decision imposed that could have been worked out by effective communication. As we all know, some insurance companies prefer litigation as the only option, but most want a resolution that is economical and fair to both sides.

For further information please contact:
A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, CO 80202
(303) 861-1000

The Best Long Distance Calling Plan For Health Care Professionals

Join Colorado Medical Society Long Distance Advantage and save up to 25% on your long distance calling while automatically receiving valuable benefits.



CMS members can now save up to 25% on long distance and be protected against loss of income due to employment-related HIV contraction through this exclusive member benefit. Coverage is automatic. Simply subscribe to the CMS Long Distance Advantage program and receive these valuable benefits at no additional cost to you.

Vital Coverage for Health Care Professionals

- *Up to \$300,000 Employment-Related HIV Supplemental Income Protection*
- *In-Hospital Indemnity \$100/day for up to 365 days*

One of the important issues for health professionals is protection against infection by HIV. Our plan gives you true peace of mind. Here's how:

It's Automatic - Your coverage begins the month after your first long distance call on the program. There are no pre-screenings, applications, or costs to you.

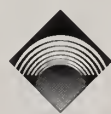
It's Substantial - You'll receive up to \$300,000* paid directly to you in 48 monthly installments to use at your own discretion. Plus, you'll automatically receive \$100/day, up to 365 days for In-Hospital Indemnity due to common carrier accidents at no charge to you.

It's Important - This plan protects your income in case of accidental contraction due to an employment-related incident and protects you from hospital costs in case of a common carrier accident.

*A complete description of coverage will be sent to you once you enroll in our CMS Long Distance Advantage program. Coverage provided by Federal Insurance Company, a member of the Chubb Group of Insurance Companies.

An exclusive member benefit that saves you up to 25% on your long distance calls and provides vital protection at no additional cost to you.

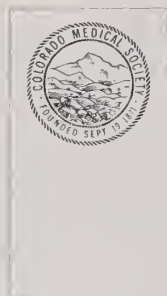
To sign up for this exclusive CMS member benefit, call 1-800-435-6832.



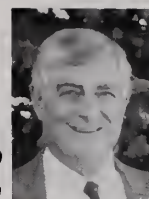
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Keycode: ANIC



THE LOBBY



Richard Allen, MD
Chairman, CMS Council on Legislation

Legend: SB = Senate Bill; HB = House Bill; HEWI = Health, Education, Welfare & Institutions Committee.

With the Colorado Medical Society Interim Meeting just ended, we are well into the legislative season. Virtually every bill that was to be introduced (including those with late bill status) has come out of committee. We now know exactly what we are dealing with. For those of you who were not at the Interim Meeting, I'll try to give you a brief rundown of where we now are.

There are nine bills on our list that we have assigned our highest priority lobbying status to, three of these bills we are supporting, five we are opposing and one we are monitoring. The bills that we support are:

HB1002, the Medical Practice Act, has passed and is awaiting Conference Committee action. This bill, and the Nurse Practice Act, have been the subject of intense scrutiny and negotiation over the past eight months. A joint committee of the involved parties, as well as the House and Senate, had several meetings and don't have any real problems with the Medical Practice Act. The Nurse Practice Act (HB 1007), however, is a different story. The same committee found it difficult to agree on some points regarding collaborative practice. The CMS Board of Directors, following the lead of the House of Delegates at the Annual Meeting, made our position quite clear, but there are some groups of nurses who have found it difficult to accept our position. Nevertheless, we feel that amendments to the bill have made it as pro-active and supportive of collaborative practice as can be done at this time. The bill has now

passed the House and Senate HEWI Committee and is awaiting action in the Senate Appropriations Committee.

Most of our support on the high priority list has been for HB1262, requiring employers to offer a point of service option to their employees. It does not mandate health insurance coverage, but the bill does state that if you are going to offer health insurance coverage to your employees you must also give them a point of service option. That is, for a slightly higher co-pay and/or deductible, the patient can opt to go out of plan to maintain continuity of care in an established patient/physician relationship. We feel quite strongly that this bill is fair and is not onerous to business. However, the National Federation of Independent Business (NFIB) has not been supportive, and as I reported last month, neither has the HMO Association nor the Hospital Association. The bill, however, did pass the House HEWI Committee and has gone on to the House Appropriations Committee, where groups opposing it hope to kill it with a large fiscal note. Our feeling is that this should have almost no fiscal note, as insurance companies have to file their plans yearly anyway, and most of them already have a point of service option. Thus, we hope the bill will come out of the Appropriations Committee to the House floor where we will then need everyone's support in contacting their representative. If and when this happens, you will receive a **Legislative Alert** for immediate action.

The third bill of high priority support is HB1332, which was a late

bill introduced by Representative Epps regarding access to health care. This bill, which would have allowed a patient who has been denied care the ability to get a second unbiased opinion, out of plan, was drastically amended to address only an appeals process for aggrieved patients. The bill is not expected to survive future legislative action but we're optimistic that a task force will be formed during the summer to address this subject.

The bills that we have opposed are: 1) SB26 on the corporate practice of medicine. As I reported to you previously, we felt there needed to be some amendments made to this bill to offer physicians protection; 2) SB45, which would require reports on health care mandates, was killed; 3) SB162, which removed the requirement that the executive director of the Department of Health be a physician, has been taken off the table. This does not mean, however, that it may not recur later, and it probably will. In the interim, we have compiled an extensive list of possible physicians who would be qualified to fill such a post.

On the House side, HB1176, the naturopath bill, has been killed, and HB1210, which would require raising our medical license fees in order to subsidize other sorts of providers who had fewer funds than we, was killed as well.

In summary, everything on our high priority list seems to be going the way we would prefer.

Items of secondary priority include:

1) Support for SB40, relating to the Health Data Commission. This has

support from our subcommittee on the data commission and is now in Senate Appropriations.

2) SB76, regarding a statewide trauma system, has been supported by CMS and has now gone to the Senate floor.

3) SB164 would require child seat restraints and further expands the seat belt law. We are supportive of this, as are the Pediatric Society and the Public Health Physicians. This bill has gone to the House Transportation Committee.

Bills which we opposed:

1) HB 1062, regarding drug manufacturer's discounts has been killed;
2) HB1123, medical record charges, has also been killed.

In addition to all of the bills I have referred to herein, there are an additional nineteen bills that we are currently monitoring. Some of which are: 1) SB41, regarding the Respiratory Care Practice Act (now in House Appropriations Committee); 2) SB116

- Prostate Cancer Screening (now on the House floor); 3) SB146 - Pharmacy Any Willing Provider bill (killed in committee); 4) HB1255 - providing liability limits for physicians giving uncompensated care (Senate HEWI Committee);

5) HB1329 - Parental Notice Act (House Committee on Veterans and Military Affairs). This would seem like a rather strange committee to assign the bill, but obviously it was done because that's where the votes were to get the bill out of committee. It has not gone to House Appropriations Committee. The bill would require notice to parents of teenage children who were seeking medical care for termination of pregnancy, and would violate AMA policy

regarding access to care and patient/physician confidentiality. It also carries significant criminal penalties with it. (You may want to refer to the March 12th *Denver Post* editorial entitled "**HB1329 puts government back in your doctor's office**".)

You can see there's a lot happening, and I'm sure things will heat up even more in the months ahead. As always, the Council on Legislation would appreciate CMS member input. As some of these bills start making it out of committee to the House or Senate floor, we will be sending out **Legislative Alerts** to which I hope you will all respond

If you need up-to-date status on any of these bills, contact the Government Relations staff at CMS.

**STOP
DOMESTIC
VIOLENCE**



Check The Box
On Your Colorado
Tax Return

Domestic Abuse Assistance
Programs Help Support

- Prevention Programs
- Safe Homes
- Counseling
- Intervention

Create the right health plan at the right cost for your business!

**Group Portfolio from Time Insurance Company offers
the coverage options you need for your business.**

Select 1 of Each...

Annual Deductible:	\$100, \$250, \$500, \$1000
Prescription Drug Card Deductible:	\$0, \$100, \$250
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Rate of Payment:	90/10, 80/20, 50/50*

* Time pays 90, 80 or 50%, you pay 10, 20, or 50% up to selected dollar amount.

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INTERIM MEETING 1995

PROCEEDINGS OF THE HOUSE OF DELEGATES INTERIM MEETING 1995

The Colorado Medical Society House of Delegates met at the Holiday Inn Southeast, Aurora, Colorado, March 11 - 12, 1995 and took the following actions:

REFERENCE COMMITTEE ON BOARD OF DIRECTORS/ CONSTITUTION & BYLAWS

Adopted a Resolution which permits the sharing of information between two component societies about a physician who is transferring membership from one society to another society

Accepted for filing:

- Progress Report - AMA Delegation
- Progress Report - Board of Directors
- Progress Report - Council on Ethical & Judicial Affairs
- Progress Report - Council on Legislation
- Progress Report - Council on Legislation/Compac
- Progress Report - Executive Director

REFERENCE COMMITTEE ON HEALTH AFFAIRS

Adopted a Resolution which states that CMS will work to improve physician knowledge about office automation techniques and be actively involved in the selection of a common protocol used for transmittal of data.

Adopted a Resolution that amended the Consolidated Managed Care Policy.

Adopted a Resolution which sunset several CMS policies addressing a variety of health care reform issues which have since been incorporated in the Managed Care Policy or the Health Systems Reform Policy.

Adopted a Resolution which amended two policy statements regarding health care reform and insurance industry legislation.

Adopted a Resolution which sunset policies on Medical Service and Public Health Related Policies.

Adopted a Resolution which ratified the actions of the Board of Directors since the last House of Delegates meeting concerned with issues addressed by the Health Affairs Council.

Accepted for filing:

- Progress Report - Health Affairs Council

Colorado Medical Society
October 31 to November 11, 1995
November 21 to December 2, 1995

TRANS-PANAMA CANAL

*Aboard the
Royal Princess*



San Juan

St. Thomas

Martinique

Grenada

La Guaira (Caracas)

Curacao

Transit the Panama Canal

Acapulco

A 12-Day

INTRAV
Deluxe Cruise

VALUE PLUS

SAVE UP TO
\$1,630
Per Person
Reserve Before
June 1, 1995

Plus
FREE AIRFARE

Plus
\$400
Per Couple
Shipboard Credit
Reserve Before
June 1, 1995

Sail from SoS Transit the Panama Canal Royal



Shining Sea... Aboard the Renowned Princess



The Panama Canal cuts a remarkable path through the western hemisphere, offering a slice of two worlds.

To build it, men moved mountains so that ships might cross the Continental Divide. Eighty years later, their accomplishments are still staggering. Even the most veteran travelers are fascinated with each new transit of the canal.

Fascinating Ports to the East and West of the Canal

On either side of Panama's engineering wonder are the magical ports of the Caribbean and the Mexican Riviera.

Eastward is the Caribbean of Spanish fortresses, Dutch shops and some of the best beaches in the world. Our Trans-Panama Canal Air/Sea Cruise takes you to the most desirable ports of call, including St. Thomas, Martinique, Grenada, La Guaira (Caracas) and Curacao.

To the west awaits Acapulco, sun and fun capital of the Mexican Riviera. Acapulco offers non-stop action and endless beaches. You'll overnight aboard ship for the ultimate in convenience.

Do what Magellan could never do. Cross from the Caribbean to the Pacific, passing through an isthmus draped in dense rain forests, where untamed jungles are filled with exotic birds and rare flora.

A Cruise Through the Voyage Through

THE EXPERIENCE

The Panama Canal is one of man's most extraordinary engineering feats. The canal took 10 years to build and cost \$525 million — in 1914! The vision and endurance required to move mountains, dig Gatun Lake and build the enormous locks astonishes even the most seasoned traveler.

A Centuries-Old Dream Come True

The canal was a profoundly important historic and human undertaking.

It was the missing link in a trade route navigators sought for centuries and never found. It is a time-saving device of 13,000 miles (the distance around South America).

The canal represented the largest, most costly single construction project ever before mounted anywhere on Earth. It held the world's attention for more than 40 years and still makes international headlines. It affected nearly every race and nationality, and for numbers of men and women, it was the adventure of a lifetime.

"Stepping" Over the Isthmus

Ships are raised and lowered in their transit of the Panama Canal via giant water stairways known as locks. No pumps are used in filling or emptying the locks. The system works on gravity, with water flowing from one level to another. Although the locks are filled at the rate of 3 million gallons a minute, the raising and lowering of the



Theodore Roosevelt
26th President of the United States — 1901-1909

It takes 52 million gallons of water to get one ship through all the locks, ocean to ocean.



Steamer Ancon starts into Culebra Cut on the official opening transit of the canal, August 15, 1914.

ships is a gradual, yet continuous process that takes a ship a full day to transit.

A Few Facts

- More than 35,000 men worked on the canal.
- Each of the 6 locks contains millions of gallons of water.
- The ship is towed through these locks by 6 "mules" (electric



During your daylight transit of the Panama Canal, you'll be taking advantage of the canal's locks. A special fascinating commentary throughout the full

locomotives weighing 55 to 60 tons (each).

- It takes 52 million gallons of water to get one ship through the locks, ocean to ocean.

The 51.7-mile canal was cut through untamed jungles, hills and swamps. More than 211 million cubic yards of earth and stone were removed.

Imagine digging a canal through a mountain range to make a dike wide enough to float the large ships of that day, constructing the largest dam ever built, designing and building the most massive locks ever conceived, and constructing the biggest gates swung.

Fascinating Full-Daytime Canal Transit

The canal runs northwest to southeast from the Caribbean to the Pacific Ocean. The *Royal Princess*

Panama Canal Is a History



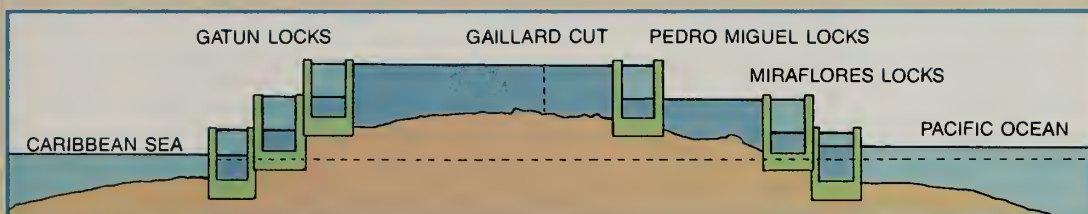
ships from around the world
will provide a

the transit by ascending 85
through the three Gatun Locks
Gatun Lake.

will cruise across 22-mile-
Gatun Lake and over the
Central Divide at Gaillard Cut.
The *Royal Princess* will then travel
through the Pedro Miguel and
Miraflores locks to the Pacific
Ocean.

As you cross the Panama Canal
on a full-day, 51-mile adventure,
you'll hear a fascinating
narration over the public
address system. A special pilot and
captain will be on board to describe
the canal's history, operation and
points of special interest. Enjoy the
adventure either on deck or from
the comfort of your stateroom.

This is a fascinating full-day canal
transit that is an experience of a lifetime.



In 1903, Teddy Roosevelt signed a treaty for the construction of a canal. The building of the canal will always be associated with President Roosevelt's vision of America's role in the world.

Sail from Old Spanish Settlements to Islands Spiced with French and Dutch

This Panama Canal cruise offers rich and diverse experiences with ports of call stretching from the Caribbean to Acapulco. A variety of optional shore excursions will be available for purchase.

San Juan, Puerto Rico

Old San Juan was originally a Spanish settlement founded in 1508 by Ponce de Leon. The 40-foot walls that surround the old city date back to 1630. It's the ideal starting point for your Trans-Panama Canal cruise.

St. Thomas, U.S. Virgin Islands

At Charlotte Amalie, you'll dock next to the main shopping district where you can browse for crystal, jewelry, linens, photographic equipment and much more from around the world.

This idyllic island is also home to Drake's Seat of Magens Bay, one of the 10 best beaches in the world.

Fort-de-France, Martinique

Martinique truly is "a bit of France in the Caribbean."

There is a distinctly French feeling about this tiny 420-square-mile island. It's plain to see on shop shelves full of Baccarat crystal, Chanel perfume and Hermes scarves. While French is the official language of the island, most native-born Martiniquais speak both true French and Creole — a melange of

French with African words and rhythms. Sample native Creole cuisine, cruise the coast aboard a catamaran, or play golf on the 18-hole Robert Trent Jones course.

St. George's, Grenada

Grenada has been called the "Isle of Spice" and "all the Caribbean islands in miniature" for good reason. The southernmost island of the Windward Antilles, Grenada is only 21 miles long and 12 miles wide; yet it encompasses an astounding variety of terrain: jungle-covered mountains, racing rivers and streams, waterfalls and lakes, and a ring of beaches of extraordinary beauty. In the island's capital, one of the Caribbean's most picturesque, shop for woven spice baskets full of island-grown nutmeg and cinnamon.

La Guaira (Caracas), Venezuela

From the teeming port of La Guaira, join an excursion to Caracas, capital of Venezuela. The city's many cultural and historical highlights include Bolivar Plaza, Old Caracas, the Capitol Building, the modern downtown area and the Colonial Museum. The coast's selection of *tipico* handicrafts include perfume, silver jewelry, Cristalart glassware, coffee and hammocks (*chinchorros*). If you like off-the-beaten-path adventure, an Indiana Jones-like excursion by four-wheel-drive vehicle provides a unique opportunity to explore the lush, tropical coast of Venezuela.

Willemstad, Curacao

Curacao, situated 40 miles off the coast of Venezuela, is the largest of



The beauty of St. Thomas makes it a holiday paradise.

the five islands that make up the Netherlands Antilles. The capital, Willemstad, is a natural berthing place for the Spanish and Dutch. See the Waterfort, which stands guard over the canal, and Fort Amsterdam. Nearby is the Governor's Palace; a walk through its archway puts you in an environment surrounded by the past. What to do in Curacao? Shop for luxury imported items such as fine English china and Swiss watches, view the wonders of the sea by glassbottom boat at the renowned Seaquarium, or see Willemstad by charming trolley train.

Acapulco, Mexico

Acapulco is the undisputed playground of the Pacific Coast, a sun- and fun-filled world of romance. Watch the daring cliff divers. Shop in fashionable boutiques. Dine at open-air cantinas along the "strip" that lines the bay. You'll overnight in Acapulco, staying conveniently aboard ship. There are plenty of beaches — alive with aquatic activities from swimming to parasailing.

ITINERARY

Day
1 Depart home city San Juan, Puerto Rico Embark the <i>Royal Princess</i>
2 St. Thomas, U.S. Virgin Islands Captain's Welcome Reception and Dinner
3 Fort-de-France, Martinique
4 St. George's, Grenada Private INTRAV Reception
5 La Guaira (Caracas), Venezuela
6 Willemstad, Curacao
7 At Sea
8 Transit the Panama Canal
9 At Sea
10 At Sea Captain's Farewell Reception and Dinner
11 Acapulco, Mexico Overnight aboard ship
12 Disembark the <i>Royal Princess</i> Return to home city

ats and Legendary Beaches

THE SHIP

D Flavors Aboard the *Royal Princess*

istened by Diana, Princess of
ales, the *Royal Princess* is still
the few ships afloat that
all outside staterooms with
picture windows. Most
oms boast twin beds that
rt to queen-size, bathtub with
r, a refrigerator and a color
ion.

ed the No. 1 cruise ship in
orld by "Lifestyles of the Rich
amous," the *Royal Princess*
acres of deck space, floor-to-
g windows and romantic
es. Fitness amenities include
sparkling pools, two
water hot spas and a fully
ed gym.

Like Never Before

ou're longing for a truly
ng vacation, here it is. Bask in
othing warmth of the sauna.
sunsets and champagne in
stateroom.

ou're looking for nonstop
ment, you'll find that, too.
to the sounds of an orchestra
y. Try your luck at roulette,
ack or the slots in the Casino.
are lavishly costumed
ctions that rival those of Las
and Broadway.

ng Aboard the l Princess

lian chefs and waiters aboard
Royal Princess bring you a
erful combination of
ssionalism and warmth with
asures of fine cuisine.

om preparation to presentation,
ish is a work of art.

Cuisine: Continental cuisine, with
regional Italian specialties,
the "house" favorite.

Dining

Choices: Full-course breakfasts,
lunches and dinners in the
dining room, or lighter fare
for breakfast and lunch on
deck. Afternoon tea and
late-night buffet.



M.V. *Royal Princess*

Length: 757 feet

Tonnage: 45,000

Registry: Great Britain



OBSERVATION DECK
SUN DECK
LIDO DECK
ALOHA DECK
BAJA DECK
CARIBE DECK
DOLPHIN DECK
(Promenade)
RIVIERA DECK
PLAZA DECK

Category	Deck	Stateroom Description	Stateroom Features
1	Lido	Suite with Veranda	Separate sitting room, queen-size bed, tub with shower, refrigerator, color TV, floor-to-ceiling windows
2	Lido/Aloha	Mini-Suite with Veranda	Separate sitting area, twin beds convert to queen, tub with shower, refrigerator, color TV, floor-to-ceiling windows
3	Aloha	Mini-Suite with Veranda	Separate sitting area, twin beds convert to queen, tub with shower, refrigerator, color TV, floor-to-ceiling windows
4	Aloha	Double with Veranda	Twin beds convert to queen, tub with shower, refrigerator, color TV, floor-to-ceiling windows, forward and midship cabins
5	Aloha	Double with Veranda	Twin beds convert to queen, tub with shower, refrigerator, color TV, floor-to-ceiling windows, aft cabins
6	Baja	Outside Double	Twin beds convert to queen, tub with shower, refrigerator, color TV, window
7	Caribe	Outside Double	Twin beds convert to queen, tub with shower, refrigerator, color TV, window
8	Dolphin (Promenade)	Outside Double	Twin beds convert to queen, tub with shower, refrigerator, color TV, window
9	Plaza	Outside Double	Twin beds convert to queen, tub with shower, refrigerator, color TV, window
10	Baja	Outside Double	Twin beds convert to queen, tub with shower, refrigerator, color TV, window (view slightly obstructed)
11	Caribe	Outside Double	Twin beds convert to queen, tub with shower, refrigerator, color TV, window (view slightly obstructed)
12	Dolphin (Promenade)	Outside Double	Twin beds convert to queen, tub with shower, refrigerator, color TV, window (view slightly obstructed)
13	Baja	Outside Double	Twin beds convert to queen, tub with shower, refrigerator, color TV, window (view entirely obstructed)
14	Caribe	Outside Double	Twin beds convert to queen, tub with shower, refrigerator, color TV, window (view entirely obstructed)
15	Dolphin (Promenade)	Outside Double	Twin beds convert to queen, tub with shower, refrigerator, color TV, window (view entirely obstructed)

This information is provided to assist you in selecting your preferred stateroom category. Please indicate 1st, 2nd and 3rd choices when making reservations. See "How to Reserve" details on back cover.

LIABILITY — TOUR PARTICIPANT CONTRACT — IMPORTANT! INTRAV, its affiliated subsidiary companies and agents (collectively, INTRAV) and sponsoring organizations act only as agent for the suppliers of transportation, accommodations, other goods and services provided to the tour participant. All arrangements for transport, accommodations and services are made upon the express condition that INTRAV shall not be liable for any direct, indirect, consequential or incidental injury, loss, accident, delay or irregularity of any kind occasioned by reason of any act or omission beyond its control, including, without limitation, any act of negligence or breach of contract of any third party such as an airline, cruise line, train, purrant, ground handler, etc., who is to or does supply any goods or services for the tour. Without limiting the foregoing, INTRAV is not responsible for any losses or expenses due to delay or changes in schedule, overbooking of staterooms, default of any third parties, sickness, weather, strikes, acts of God, acts of terrorism, force majeure, war, quarantine, criminal activity, or for any other cause beyond its control. INTRAV reserves the right to change the itinerary of the tour at any time prior notice. If the tour is cancelled by INTRAV for any reason, INTRAV shall have no liability beyond the refund of all tour participants' deposits received by it. INTRAV may increase the tour price in the event of cost increases. INTRAV may accept or retain any tour participant as a participant on the tour at any time. If any tour participant leaves or is removed from the tour, a refund only for refundable unused services shall be made. These tours may be sold in conjunction with the sale of any airline. The price of your *Trans-Panama Canal Air/Sea Cruise* is based on varied promotional airfares. Effective March 15, 1995. The passenger tickets in use by the carriers, when issued, shall constitute the sole contract between the carrier and the passenger; the carriers are not responsible for any act, omission, or event during the time tour participants are not aboard their conveyances. Any litigation concerning this tour must be brought in the state of Missouri. Changes in the **LIABILITY** clause can be made only in writing signed by an officer of INTRAV. Deposits paid by tour participants indicate acceptance of the above terms and conditions. Ship's registry: Great Britain.

NOTES: Final payment for all tours is due 70 days prior to departure date. All cancellations for any reason whatsoever will be subject to a \$100 per-person administrative fee. In addition, cancellations 70 days to 4 days prior to departure are subject to a 50% cancellation fee per tour participant; cancellations within 3 days of departure will result in forfeiture of the entire cost of the trip. Domestic airfares are subject to applicable airline cancellation fees, are subject to change without notice and are included in the trip cancellation fee above. All cancellations or claims for refund must be submitted in writing to INTRAV.

Here's How to Reserve Your Trans-Panama Canal Air/Sea Cruise:

Send to: Colorado Medical Society
c/o INTRAV — 9th Floor
7711 Bonhomme Avenue
St. Louis, MO 63105-1961

Royal Princess; prices are per person, double occupancy, INTRAV SAVER — Reserve by June 1, 1995					
Category	Deck	Description	Regular Price	SAVE	You Pay
1	Lido	Suite with Veranda	\$6920	\$1630	\$5290
2	Lido/ Aloha*	Mini-Suite with Veranda	5987	1397	4590
3	Aloha*	Mini-Suite with Veranda	5587	1297	4290
4	Aloha	Double with Veranda	4487	1022	3465
5	Aloha	Double with Veranda	4387	997	3390
6	Baja	Outside Double	3820	855	2965
7	Caribe	Outside Double	3720	830	2890
8	Dolphin	Outside Double	3620	805	2815
9	Plaza	Outside Double	3520	780	2740
10	Baja*	Outside Double	3420	755	2665
11	Caribe	Outside Double	3320	730	2590
12	Dolphin	Outside Double	3220	705	2515
13	Baja*	Outside Double	3120	680	2440
14	Caribe	Outside Double	3020	655	2365
15	Dolphin	Outside Double	2920	630	2290

Please refer to page 7 for stateroom features.

Port Taxes: \$154 per person

Limited singles are available. Single pricing is 200% of the sharing twin price for categories 1 through 5; and 160% of the sharing twin price for categories 6 through 15.

*Limited triples available in this category; because third person travels at a reduced rate, the INTRAV Saver discount and shipboard credit do not apply to third person.

Round-trip flights to San Juan/Acapulco can be arranged from:
Denver FREE

Airfares from other departure cities available upon request. **Indicate your departure city on the reservation coupon.** The fare will be reflected on your final invoice.

Enclosed is my deposit of \$_____ (\$500 per person) for the Trans-Panama Canal Air/Sea Cruise. I understand that reservations must be paid in full 70 days prior to departure. Category assignment will be made in the order of receipt of deposit.

My stateroom category preferences are: **1st** _____ **2nd** _____ **3rd** _____

Dining preference: ☐ Main seating (6 p.m.)
(confirmed on board) ☐ Second seating (8 p.m.)

Name _____
Last (as it appears on your passport) Title First Initial

Name _____
Last (as it appears on your passport) Title First Initial

Home Address _____

City _____ State _____ Zip _____

Area Code _____ Home Phone _____ Office Phone _____

☐ Enclosed is my deposit check, made payable to INTRAV.

☐ Charge my deposit to: ☐  ☐  ☐  ☐ 

Card Number _____ / _____
Expiration Date

Signature (as it appears on your card)

Please reserve flights to San Juan and return from Acapulco, from _____
(Departure City)

☐ Do not make flight reservations.

Please seat me, where available, in ☐ Smoking
☐ Nonsmoking

I will depart on ☐ October 31, 1995 ☐ November 21, 1995

✂ For Reservations Call **1-800-456-0020** (9:00 a.m. to 5:30 p.m. Central time). Your Reservation Code Is: **07004-TPRP95-02**

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- Deluxe travel bag
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Optional insurance coverage is available for Baggage, Accident and Trip Cancellation/Interruption at special low-cost group rates.

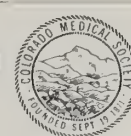


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INTERIM MEETING 1995



These are the people who represented you in making the decisions on the preceding page. Please thank them for their participation.

COMPONENT/SPECIALTY SOCIETY
Delegate/Alternate

ARAPAHOE

Bartee, Roy
Barter, Jeffrey
Bartlett, Max
Burks, Jack
Capek, Richard
Gulevich, Steven
Jolly, Susan
Larkin, Thomas
Larsen, Lawrence
Levine, Mark
Lewis, Frederick
Ozog, Mark
Scanlon, Charlotte
Stecher, Karl
Truitt, Leigh
VanderArk, Gary
Varani, William
Vernon, Walter

AURORA-ADAMS COUNTY

Aboaf, Alan
Buckley, Jerome
Gottula, Roderic
Heaton, Angeline
Heaton, Carl
O'Dell, Robert
Spaulding, Harry
Sundland, Barry
Unrein, Christopher
Visconti, Paul

BOULDER COUNTY

Baumgardner, Jan
Benson, Alan

Curtis, William
Kelley, Severance
Mooney, Herbert
Rupp, Gerald
Steinbaugh, John
VanHook, Charles

CLEAR CREEK VALLEY

Brundige, Richard
Chambers, Jodi
Day, James
Doig, William
Dorr, Eugene
Dougall, Dorin
Doyle, Herman
Furman, Joseph
Golbert, Thomas
Henbest, Philip
Kief, Jan
Mains, Charles
Mozia, Nelson
Netz, Howard
Oppenheim, Walter
Parry, Lynn
Sadler, Dean
Tegtmeier, Ronald
Yocum, Harold

CO ALLERGY SOCIETY

Olson, Grant

CO SOC. OF CLINICAL PATHOLOGISTS

Merrick, Thomas

DENVER

Allen, Richard
Anneberg, Lee
Ballinger, Carter
Barmatz, Hirsh
Campbell, William
Cochrane, David
Converse Walker, Louise
Fink, Donald
Foust, Glenn
Jacobs, Mary Jo
Kandel, George
Karel, James
Kelble, David

Kinzie, Jeannie
Lightburn, John
Manart, Frank
McCartney, Robert
Nelson, Nancy
Rainer, Gerald
Reed, Barbara
Rumack, Carol
Sawyer, Robert
Schemmel, Janet

EASTERN COLORADO

Fox, John

EL PASO COUNTY

Brusenhan, Richard
Cole, Norman
Crawford, Lewis
Cunningham, Leon
Feinsod, Fred
Fitzgerald, Edward
Goldmuntz, Barry
LaVoo, John
Lloyd, William
Nielsen, Peter
Pero, Robert
Pollard, Joseph
Sherman, John
Spaulding, Duane
Struck, Teresa

FREMONT COUNTY

Buglewicz, John
Gamache, Peter

LA PLATA COUNTY

Tarantino, Lesley

LARIMER COUNTY

Belleville, Bruce
Carroll, Cory
Eriksen, Christopher
Ezell, William
Honea, Bertrand
Kirk, John
Rule, Ingrid
Tagge, Gordon
Vedanthan, P. K.

LAS ANIMAS COUNTY



INTERIM MEETING 1995

McFarland, Douglas MEDICAL STUDENT COMPONENT

Clark, Pat
Eisenach, John
Fetterman, Hilary
Harris, Shanna
Klancar, Lilly

MESA COUNTY

Doran, John
Hanna, Robert
Moore, Richard
Sadler, Theodore
Smith, Verne
Webel, Jacob

MORGAN COUNTY

Thompson, Patrick

MT. SOPRIS COUNTY

Painter, Ray
Rodriguez, Jose

NORTHEAST COLORADO

Bonelli, Joseph
Rish, Ronald

OTERO COUNTY

Satt, James

PUEBLO COUNTY

Drake, Robert
Lawrence, Richard
Morgan, Alethia

Parks, Gary
Ryals, Jarvis
Snyder, Charles
Wilz, William

SAN LUIS VALLEY

Brownrigg, Richard

WELD COUNTY

Flower, Thomas
Foult, Arnold
Vaughan, Judith

WOMEN IN MEDICINE SECTION

VanScoy, Sarah

138 Attendees

Prayer for Interim Session of House of Delegates

*M. Robert Yakely, MD
March 11, 1995*

God, we are gathered together here this morning as a group of physicians and those who have chosen to help physicians, in order to discuss issues that are important.

Those gathered here come from different traditions, but it doesn't really matter whether we call you Father, Yahway, The Great Spirit, or The Enlightened One, we take this time now, because we each acknowledge that there is a powerful force that our religious tradition brings to our lives that influences our decisions for good.

We ask that your loving presence be with us throughout this weekend. Give us the patience and sensitivity with which to listen to differing points of view. In all that we do, Father,

help us to remember that our solutions must be designed to benefit those we serve. At this time, many physicians have expressed increasing frustration with the practice of medicine in our society. Help us look to our values for enduring solutions to our problems.

I was reminded how important our values are when I was in Viet Nam, last year. I spent a week in Hanoi with 78 year old Dr. Trieu, watching him work from 7am. to 6pm. six days a week for \$50 a month, with very inadequate tools, so that he had to live with a high incidence of complications. Because of his low salary, he rode the three miles to the hospital on a bicycle and lived in a one room home with no utilities. I asked him why

he had stuck with practicing medicine for the past 50 years? His answer was touchingly simple. He said, "It is because I love my patients."

Father, my love has never been tested to this degree. The situation in which I live and my practice is much more comfortable, but if you asked this of me, I hope I would be able to give you the same answer.

God, as we seek solutions this weekend, let Dr. Trieu's answer remind us of something we all know, and that is that as physicians, we are living up to our best and highest values, when we serve our patients because we love them.



HIGHLIGHTS OF BOARD OF DIRECTORS MEETING March 10, 1995

- Copic:** Dr. Buckley stated that he would be reporting in detail to the House of Delegates regarding loss ratios, purchase of the Gadrian Company and other items of interest to CMS Membership. Additionally, he indicated that Copic was working on legislation, with CMS staff assistance, dealing with pro bono medical services and liability.
- Medical Executive Group:** Ms. Hawthorne-Shriver reported that the group was considering forming a Colorado Chapter of the American Association of Medical Society Executives.
- Board of Directors:** The Board approved a position statement on Expert Witness, submitted by the Workers' Compensation & Personal Injury Cmte, which identified appropriate information versus the inappropriate information which may be requested by attorneys.
The Board approved CMS involvement with a Provider Coalition with the clear understanding that differences will arise and that CMS will not be listed as a member when CMS individually is in opposition to a particular piece of legislation.
The Board approved a monies advance to purchase supplies and copyright permission to begin the "My Doctor, My Choice" campaign.
- Executive Director:** Ms. Maloney reported that CMS memberships had reached an all time high of 5000 plus.



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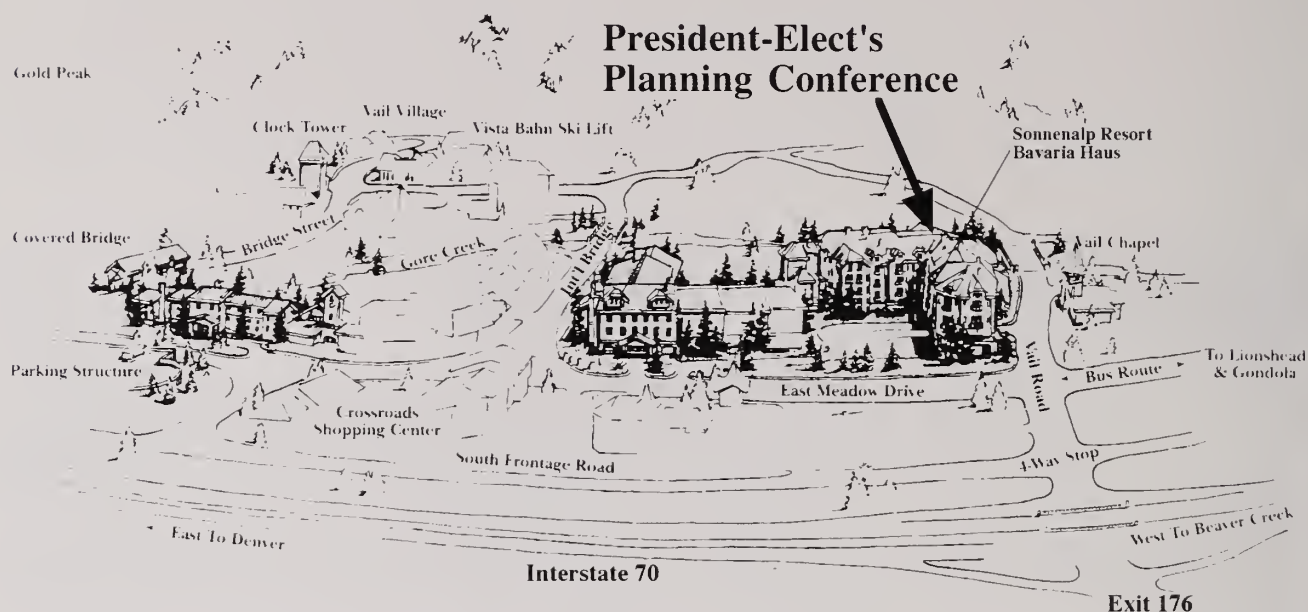
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How to get to the CMS Leadership Conference



Daniel "Stormy" Johnson, Jr., MD to keynote Leadership Conference



Daniel Johnson, Jr., MD

Daniel Johnson, Jr., MD, a diagnostic radiologist from Metairie, Louisiana, was reelected speaker of the American Medical Association (AMA) House of Delegates in June 1994. Prior to becoming speaker in 1991, Dr. Johnson had been vice speaker since 1987. He has served as a delegate since 1983 and as an

alternate delegate from 1980 to 1982.

Long active in organized medicine, Dr. Johnson chaired the Louisiana State Medical Society's (LSMS) committees on long-range planning, advertising and fee complaints, and alternative delivery systems. He was speaker and vice speaker for the LSMS House of Delegates for eleven years and is a past president of the society. He is a member of the board of the Louisiana Medical Mutual Insurance Company (LAMMICO) and active on its Loss Prevention/Marketing Committee. Dr. Johnson is also a past chair and treasurer of the Louisiana Medical Political Action Committee (LAMPAC). Since the summer of 1992, he has represented the physicians of Louisiana on the Louisiana Healthcare Commission.

Born April 3, 1938, in Port

Arthur, Texas, Dr. Johnson received his MD degree from the University of Texas at Galveston where he interned in surgery. Following two years of service with the Army, including duty in Viet Nam, he trained in diagnostic radiology at the Ochsner Foundation Hospital in New Orleans. He is board certified in diagnostic radiology and a fellow of the American College of Radiology. He maintains an active private practice of diagnostic radiology.

Dr. Johnson is clinical associate professor of radiology and otolaryngology at Tulane University. He was cofounder and president of the American Society of Head and Neck Radiology. He also is a past president and past chair of the board of the New Orleans Radiology Society.

Dr. Johnson and his wife, Susan, are the parents of two daughters.

Ready, Set, Go!

Dear Colleague:

Can you believe the changes that continue to occur, day after day, which affect the way we practice medicine? Do you feel a bit uneasy about your future? Do you get a "sick" feeling in the pit of your stomach each time you go to a hospital meeting? or open a letter from an insurance company? or sign for a certified letter? It is very difficult to be "out there" on your own, today.

Is there an easy way out? early retirement? career change? even the recognition of a career-ending disability to make up for all the years you have paid that insurance?

At the **new, energized** Colorado Medical Society, we have a better idea! If ever there was a time for physicians to unify and plan for the future, that time is now. CMS has just begun to take control of the issues which affect our lives. From a strong voice in the legislature to address issues such as non-physician scope of practice, to corporate practice of medicine, to patient access to a physician of their choice...to the negotiating table to deal with HMOs...to development of a patient-physician collaborative effort to change the current climate...to the potential development of a physician-owned, physician-controlled managed care entity to provide the public with better health care at affordable prices, Colorado Medical Society is out there representing the interests of you and your patients.

As I promised last year when I campaigned for the office of CMS President-elect, we will begin a grass roots planning process this spring to

develop our **Program for Work** which will start at the CMS Annual Meeting this September. This will be our agenda for the first 100 days of my term as CMS President. Dr. David Martz has geared up this Society, and I intend to make it fly!

The process will start at the **CMS Leadership Conference** to be held May 5-7, 1995, at the Sonnenalp Resort in Vail, Colorado. Our keynote speaker will be Daniel "Stormy" Johnson, MD, current Speaker of the AMA House of Delegates, soon to be the next President-elect of the AMA. He will discuss with us Friday night what the AMA is doing to provide physicians with access to patients and will kick off our planning process on Saturday by discussing the value of the planning process for medical societies. We will then hear from four CMS physician leaders who will lead the discussion on different issue areas to be addressed next year. Each attendee will be asked to sign up for one of the four issues, participate in the discussion, and help formulate a set of resolutions to be refined by late July and presented to the CMS House of Delegates for deliberation in September.

If you believe as I do that the time is now for Colorado physicians and their patients to take back control for our health care delivery system and write its future agenda, please attend our CMS Leadership Conference, May 5-7 in Vail. I need your input! For those of you who have called me repeatedly to gripe about your plight and your own perceptions of CMS, now is the time to show up and make your views heard!

Please fill out and return the accompanying registration form, so that together we can work for a better tomorrow. Our patients deserve our help!



*Joel M. Karlin, MD
President-Elect
Colorado Medical Society*

President-elect's Leadership Conference
Ready, Set, Go!
Developing Our Program for Work
May 5-7, 1995, Sonnenalp Resort, Vail, Colorado

REGISTRATION FORM

Yes, I (we) plan to participate in **Ready, Set, Go!** May 5-7 in Vail and will attend the following:

PHYSICIAN

☐ Friday evening dinner

☐ Saturday/Sunday Conference

SPOUSE

☐ Friday evening dinner

☐ Saturday/Sunday Conference

I am (we are) interested in the following Issue Group(s)—check all that apply; if you select more than one, we will make the final assignment:

Issue 1 – **Patient Access and Fairness** – Tom Allen, MD and Eugene Sherman, MD

PHYSICIAN

☐

SPOUSE

☐

Issue 2 – **Integrated Delivery Systems (IDS)** – Bob McCartney, MD

☐

☐

Issue 3 – **Rural Health Issues** – Jack Berry, MD

☐

☐

Issue 4 – **CMS Legislative Efforts** –

☐

☐

Name _____ Spouse's Name _____

Component Society _____

Mail your completed registration form to:

CMS, PO Box 17550, Denver, CO 80217-0550

Fax: 303-771-8657 or Phone: 303-779-5455 or 800-654-5653

Sonnenalp Resort of Vail

Preregistration form

Group Name: Colorado Medical Society

Name _____ Area Code and Phone Number _____

Address _____ City _____ State _____ Zip _____

Number in Party _____ Arrival Date _____ Departure Date _____

Credit Card Information:

Please Note: A deposit equal to two night's stay will be charged to your credit card. Balance is due upon checkout.

Check one: ☐ MasterCard ☐ Visa ☐ Diners Club ☐ American Express

Credit Card Number _____ Expiration Date _____

Cardholder's Name as it appears on the card _____

Special Seminar/Conference rate will be extended to attendees for longer stays.

Desired Accommodations:—Bavaria Haus Suites: ☐ King Bed ☐ 2 Double Beds

\$120 per night, Single or Double Occupancy—Number of Units: _____

Bavaria Haus suites all contain gas-log fireplace, large baths with soaking tub big enough for two, separate shower, heated tile floor, walk-in closet, TV, VCR, fully-stocked mini-bar, hand-carved pine Bavarian furniture, and down comforters on all of our beds.

Rates include a full European-style breakfast in the dining room.

There will be an additional charge of \$25.00 per night for each person over 12 years of age exceeding Double occupancy.

(Note: most suite types cannot accommodate more than 3 adults.)

Reservations received after April 14, 1995, will be taken on a space available basis only.

Cancellation Policy: In the event of cancellation 30 or more days prior to arrival, you will incur a \$50 per room penalty in handling charges. In the event of cancellation between 30 and 14 days prior to arrival, you will incur a one-night cancellation fee, if you cancel less than 14 days prior to arrival, you will incur a two night cancellation fee.

Reservations will be taken with this form or call our reservations Department at (800) 654-8312.

Please mail this form to:

Sonnenalp Resort, Attn: Group Reservations, 20 Vail Road Vail, CO 81657

Colorado Medical Society
Leadership Conference

May 5-7, 1995—Sonnenalp Resort Vail
Schedule

FRIDAY, MAY 5, 1995

12:00 N - 2:00 pm	Rural Health Task Force
1:30 p.m. - 3:00 p.m.	Finance Committee
3:00 p.m. - 6:00 p.m.	Board of Directors
7:00 p.m. - 7:30 p.m.	Cash bar
7:30 p.m. - 9:00 p.m.	Dinner
-	"What is the AMA Doing to Provide You with Access to Patients?"
	Stormy Johnson, MD

SATURDAY, MAY 6, 1995

8:00 a.m. - 8:10 a.m.	Welcome, Conference Overview—Joel M. Karlin, MD
8:10 a.m. - 9:00 a.m.	"The Planning Process for Medical Societies" —
-	Stormy Johnson, MD
9:00 a.m. - 9:10 a.m.	Creation of "CMS Program for Work" for 1995-96 —
-	Joel M. Karlin, MD
-	Process for identifying issues and creating resolutions for the Annual Meeting of September 1995
9:10 a.m. - 9:40 a.m.	Issue 1—Patient Access and Fairness—Tom Allen, MD (Primary Care) and Eugene Sherman, MD (Specialty Care)
9:40 a.m. - 10:00 a.m.	Audience Impact on Issue 1
10:00 a.m. - 10:20 a.m.	Issue 2—IDS—Bob McCartney, MD
10:20 a.m. - 10:50 a.m.	Audience Impact on Issue 2
10:50 a.m. - 11:10 a.m.	Issue 3—Rural Health Issues—Jack Berry, MD
11:10 a.m. - 11:40 a.m.	Audience Impact on Issue 3
11:40 a.m. - 12:00 N	Issue 4—Legislative Matters—Rich Quinn, MD
12:00 Noon - 12:30 p.m.	Audience Impact on Issue 4
12:30 p.m. - 2:00 p.m.	Lunch—on your own
2:00 p.m. - 2:20 p.m.	Forming Alliances—The Who and How of It
-	Joel M. Karlin, MD
2:20 p.m. - 2:40 p.m.	Patients—My Doctor, My Choice—Ms. Edy Hughes, CoChair, CMS Patient Advisory Committee
2:40 p.m. - 3:00 p.m.	University Physicians—Dick Krugman, MD
3:00 p.m. - 3:20 p.m.	Kaiser Physicians—Ned Calonge
3:20 p.m. - 3:40 p.m.	Coalition of Physicians (COPS)—Ian Levenson, DO, Colorado Society of Osteopathic Medicine
3:40 p.m. - 4:00 p.m.	Other Physician Groups—Hal Crane, MD, Denver orthopedic Clinic
4:00 p.m. - 4:25 p.m.	Discussion and Questions
4:25 pm - 4:30 pm	Thoughts for Sunday
	Joel M. Karlin, MD
4:30 pm - 6:00 pm	Nominating Committee
5:00 p.m. -	Dinner/Evening on your own

SUNDAY, MAY 7, 1995

8:30 a.m. - 8:40 a.m.	Where Do We Go from Here? — Joel M. Karlin, MD
8:40 a.m. - 9:30 a.m.	Breakout Groups Issues 1-4
9:30 a.m. - 10:10 a.m.	Report—Issue 1 Group—Tom Allen, MD and Eugene Sherman, MD
10:10 a.m. - 10:30 a.m.	Break
10:30 a.m. - 11:10 a.m.	Report—Issue 2 Group—Bob McCartney, MD
11:10 a.m. - 11:50 a.m.	Report—Issue 3 Group—Jack Berry, MD
11:50 a.m. - 12:30 p.m.	Report—Issue 4 Group—Rich Quinn, MD
12:30 p.m. - 12:35 p.m.	Concluding Remarks—Joel M. Karlin, MD

..... Time Table for Resolutions from each group:
 Initial resolution(s) due @ CMS **June 5**
 Initial resolution(s) distributed to members of Planning Session for comments **June 10**
 Comments on resolutions due back to CMS by **June 30**
 Resolutions with comments sent to assigned person by **July 7**
 Final resolutions due by **July 28**

Celebrate

Happy 20th Birthday



The **Hall of Life** at the Denver Museum of Natural History exists to provide innovative exhibits and dynamic educational programs to people of all ages. This effort seeks to teach how the body functions, motivate positive health choices and emphasize the role of personal responsibility in health and fitness.

The Hall of Life was founded in 1975 and provides interactive, hands-on learning experiences. Actual medical specimens, high quality models, and one of a kind exhibits

make health lessons come alive, offering visuals and teaching materials of interest to children and adults.

More than one and a half million people have visited the Hall of Life exhibits since 1989, including almost 300,000 in 1994. In addition, the Hall of Life has hosted in-house programs, exhibit tours and outreach programs around the state, plus programs designed to educate all age groups from school children through parents and seniors.

Come Celebrate with us

Friday, May 5, 1995

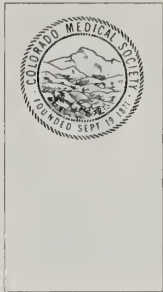


Denver Museum of Natural History
6:00 pm Cocktails – 7:30 pm Dinner

Reservation Deadline: April 21, 1995—Seats are \$75 each (tables of 10)

Please consider the size of your birthday gift to the Hall of Life to provide scholarships and materials for hands-on health education programs for children. \$500 will provide two Hall of Life instructors to present ten classes for a metro area school of your choice.

Call 303-329-5433 Now



Patti Brown, President
Colorado Medical Society Alliance

March was designated as Medical Alliance Month, by Barbara Tippins, AMA Alliance President. March was the month that Alliances across America sponsored events to let the public know who we are and what we do in our communities.

The Metropolitan Denver Medical Societies Alliance distributed the workbook *I Can Choose* to area elementary schools. This workbook provides a fun way for young children to learn non-violent conflict resolution. The MDMSA in conjunction with the Aurora-Adams Medical Society, the Denver Medical Society and the Arapahoe Medical Society have made arrangements to have Public Service Announcements on 10 billboards around the metro area. The bright red billboards say "Stop the Violence ...Start Young to Learn the Difference" and include a picture of the *I Can Choose* workbook with a number to call to order the book.

The Mesa County Alliance also distributed the workbooks to all Mesa County First graders. The Larimer County Alliance had a meeting to address the problem of "Gangs in Fort Collins". The El Paso Alliance planned a meeting at the Center for the Prevention of Domestic Violence.

Patti Brown

You're Invited to the Hall of Life Birthday Party Friday, May 5, 1995

See additional information on facing page

As a member of the committee, let me inform you, there will be a Birthday party to celebrate the 20th anniversary of the Hall of Life on Friday, May 5, 1995. Tickets are \$75 each and provide scholarships for qualifying children to attend the exhibits, and health education classes. If you would like to attend, please contact:

Patti Brown
6865 W Princeton Ave
Denver, CO 80235
303-988-0888

D_{oing} for your country

Rosemarie Lyons, Colorado Springs, Colorado

This Month's Winner in the CMS Essay Contest

Introduction: *In response to a resolution from Arapahoe Medical Society at the Annual Meeting in September, the Colorado Medical Society established an essay contest on health care reform. After plans were finalized by the Executive Committee on January 4, 1995, news releases and other information went out to various media outlets in Colorado. The idea behind the contest was to get input from the end users of health care (your patients) concerning how the system should work. The response indicates that patients are grateful their physicians desire their opinions and input.*

Here we publish the second of three monthly winners. Ms. Lyons and two others will receive checks for \$100 for their entries. There will also be a grand prize of \$500 and a second prize of \$200, to be awarded in June.

It has been my secret wish to tell our First Lady, with all respect, where she and others before her went wrong. My ideas are based on the words of J. F. Kennedy, who said, "Don't ask what your country can do for you, but what you can do for your country."

My ideas, if put into practice, would not increase the deficit and could decrease health care expenses.

If every physician in the country would be willing to donate one afternoon a month to treat uninsured, qualifying patients for free,

If nurses and health care workers would volunteer a few hours to visit home bound patients,

If the IRS would allow a substantial tax credit for those voluntary services,

If insurance companies would give reduced rates for non-smokers, people of normal weight, low cholesterol and blood pressure,

If (on the assumption that education and prevention could reduce health problems) every pharmacy and doctor's office would show videos on the dangers of smoking, drug use and dietary hazards,

If students in class were to see the nice pink lungs of nonsmokers and the pitch black lungs of smokers (in jars of formaldehyde),

If High School girls would meet and talk with unmarried teenage mothers, they might change their minds about risking pregnancy,

If students were taken to the bedside of people dying of AIDS they might think twice about having unprotected sex,

If at Congress sessions a pretty girl would pass around a list, asking for pledges of members, to be paid into a Trust Fund for uninsured qualified people on a monthly basis,

If every citizen would be asked to contribute \$10 and \$20 to this Trust Fund voluntarily,

If Hospitals would not charge outrageous prices for toothbrushes, band-aids, soap and aspirins, etc.

I realize that many of my ideas are already being carried out in certain states and by certain individuals, but if done on a nationwide basis, they surely could have an impact on our healthcare reform.

People are proud, when they give and contribute, because *they want to*, not because they have to! Of course, the best advice to people, especially uninsured ones, in respect to medical expenses would be: *Just don't get sick!*

PATIENT ADVISORY COMMITTEE

The newly appointed Patient Advisory Committee, co-chaired by Joel M. Karlin, MD, and Edy Hughes of Kinzley-Hughes, has met three times and will meet again on March 30. The purpose of the committee is to provide a mechanism for patients to inform CMS of their positions on issues of importance to them as patients. In addition, the committee will serve as a forum for open

discussion of issues of mutual concern for patients and physicians. Because of its timeliness, the main topic of discussion at past meetings has been HB 1262, the point of service bill sponsored by CMS. The Committee will be discussing other issues of importance to patients and physicians, including Senior health plans and involvement of young patient members and issues of importance to them.

A monthly report of current and ongoing activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.

It's what's inside that counts



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Heroes Don't Whine

by Roger C. Shenkel, M.D.
Grand Junction, Colorado

"Specialists and Primary Care Physicians -- Let's take another look."



Roger C. Shenkel, M.D.
Family Practice

Medical care in Western Colorado has evolved out of synchrony with the rest of the state. Because of Rocky Mountain HMO and the Mesa County Physicians IPA (all inclusive, non-competitive), we have been managing care since 1974. Currently, over half of our private business, 80 percent of our Medicaid, and 65 percent of our Medicare is managed through a system we have evolved¹. We have a message for the rest of the state: ***Don't let the "G" word get in the way of physician teamwork.***

We have done "gatekeeping" (the G word) for 20 years. It represents a necessary transition from the old ways to the critical integration of physician services needed to be competitive in the future. Gatekeeping accomplishes some cost savings and creates lots of ill will. Physician-directed case management then becomes the next phase, where the most appropriate care is delivered by the most appropriate physician in the most appropriate facility for the lowest possible cost compatible with quality care--as judged by a physician.

This additional shift can be painful if it is slow in coming. I recently submitted the following article to the family physicians of the state of Colorado in an attempt to moderate some of those feelings.

HEROES DON'T WHINE²

Specialists have become media and government targets for the ills of our healthcare system. They make easy targets. Society asked them to do one thing, and the Specialists did it very well. Now society has chan-

ged part of its mind some of the time and is looking for a culprit. Lately that culprit has been Specialists.

As part of this attitudinal shift, Primary Care Physicians (PCPs) have been cast as the victims of the past and the heroes of the future. We are quite good at being victims, for we have a long tradition in that role. The hero thing is new to us, and we are not too smooth at it.

Managed care has made us acutely aware of Specialists' incomes. PCPs have to pay attention to Specialist's fees when all the fee money comes out of one limited pool. Sometimes we agree with the media/governmental diatribes, but we easily are lured into an area where we should tread very lightly, if at all.

Primary Care Physicians may be unhappy with the relative size of our fees as they compare to Specialists' fees, and we may be unhappy with other perverse incentives in our healthcare system, but we should not confuse that with the incomes that Specialists make. Criticizing a person's income turns a philosophical discussion into a personal affront. A Specialist's income is not his fault but rather the result of a very peculiar, poorly designed health financing system--designed one part at a time and hugely mismanaged by the government. This is the system that the Specialists and the Primary Care Physicians signed up for.

Both groups have adapted to the life-styles of their particular incomes. It is not the fault of the Specialists that Primary Care Physicians make what they make. It is not at all becoming for Primary Care Physi-

¹ "Rural Managed Care: A 20-Year Road to Success," Family Practice Management, October 1993.

² Colorado Family Physician, 3rd Quarter 1994.

The ideal system has a primary

As PCPs, we have the best job in the world--unless your goal is to be wealthy without much effort. It is no one else's fault if you chose your

We need to recognize that our colleagues are the ones we should work with closely and look to for help as we shape the future. We should not let insurance companies or hospitals keep us from working together. We have done it slowly in Mesa County. The physicians of Eastern Colorado need to do it quickly.

RAM

Recent Affiliations and Mergers (in Colorado)

*Prepared by the Colorado Medical Society Dept. of Health Care Policy
Lorraine Heth, Program Manager*

Key: DP = Denver Post; CMC = Colorado Managed Care Newsletter; RMN = Rocky Mountain News; DBJ = Denver Business Journal;
C/M = Colorado Medicine

"... the deal, if made, would create the largest publicly held managed health-care company in the nation."

- Health Systems International, the parent of Pueblo-based Qual-Med, is now in sale talks with WellPoint Health Networks, Inc., a California rival. A person close to the talks said that the deal, if made, would create the largest publicly held managed health-care company in the nation. Currently, HSI has HMOs in Colorado, Idaho, New Mexico, Oregon and Washington. (DP 3/9/95)

Columbia/HCA Update

- Columbia/HCA discussions with HealthONE System are on hold. It is reported that HealthONE's board of directors is not interested in the offer

in its present form. It is speculated that a HealthONE/Columbia deal would have meant the eventual closure of a central city hospital and an Aurora Hospital. (RMN 2/10/95)

- Children's Hospital has turned down a buyout offer by Columbia/HCA. Several experts say it was a good decision by Children's board, however, there are many challenges being faced by the hospital including increased competition from the community for pediatric patients, managed care pressures, decreased inpatient business, and high expenses. (DP 2/28/95)

- Columbia-HCA Healthcare Corp.'s \$5.4 billion acquisition of HealthTrust Inc. was approved February 28 by shareholders at both hospital companies. The shareholder approvals come about two weeks after the companies, the nation's two largest hospital chains, agreed to sell off three Utah hospitals to satisfy antitrust concerns.

(DP 3/1/95)

- HealthONE has re-opened talks with Lutheran Medical Center and St. Joseph Hospital about a potential partnership. A Lutheran spokesman is reported to have said, "To the extent HealthONE is interested in our Primera strategy, we're interested in talking with them." Primera Healthcare is a joint venture between St. Joseph and Lutheran involving medical care delivered outside hospitals, in clinics or doctors' offices. HealthONE's renewed overtures to not-for-profit hospital colleagues in Denver signal its interest in finding an alternative to a deal with Columbia/HCA Healthcare Corp. (DP 2/15/95)

Other News of Related Interest:

- Eli Lilly & Co. has increased its indirect ownership in Golden-based Integrated Medical Systems Inc. by another 3 percent bringing its stake to 29 percent. Integrated Medical has medical communication networks in 47 markets. (DBJ 3/3-9/95)
- A survey by HealthCare Computer Corp. of America, a Denver firm, reported there are 96 managed-care networks in Colorado as of December (up from 69 last year) and 43 physician-hospital organizations in the state (up from 32 a year ago). (DP 3/2/95)

Medical Groups:

- An administrator of Focus said the group plans to expand statewide. In the past year, they have doubled in size to 70 doctors.

Last October Boulder Medical Center PC signed a 40-year affiliation agreement with Nashville, Tenn.-based PhyCor. The agreement gave PhyCor a voice in management decisions and ownership of the practice's assets. The group has 44 doctors in three locations.

Rocky Mountain Health Centers has the financial backing of giant for-profit hospital company Columbia/HCA Healthcare Corp. Nashville-based Columbia owns 92 percent of Rocky Mountain Health Centers' management arm, Colorado Healthcare Management. It was created in 1993 from the purchase of the now defunct Accord Medical Centers. (DBJ 2/24-3/2/95)



by **Bill Pierson**, Director
Member Services
Colorado Medical Society

Alpine Adventure! Oh! To be the tour director.

I walked out onto the street from the Breinoessl Hotel, about 6:30 Saturday morning, a grey, overcast dawn, the sun slow to show itself. There was little movement on the street. . . an elderly woman who looked the part of a "char-woman" going home from work or to her cleaning job -- I am sure she looked the same in either direction -- stooped, mostly looking down at the pavement until a trolley car approached. She picked up her nondescript canvas bag and plastic grocery sack and got on, the only passenger, and the car moved away almost seamlessly. Obviously, she and the trolley had rehearsed this scene many times. The street was again silent and motionless.

We arrived in Innsbruck last night, so I couldn't see much. This morning, as I came out of the hotel it was almost eerie. . . this strange European city. My attention was caught by the char woman, and I started mentally building all kinds of characters and lives into the picture. When the trolley had gone and I was alone with my thoughts, I turned and looked left. It was one of the older main downtown business arteries -- wide, with "light rail" tracks in the pavement, trolley wires overhead, and both sides of the street lined with storefronts, mostly in two and three-story buildings. Everything so clean and neat! About a block to my left, the street narrowed to more of an alleyway. It was then that the fog and haze thinned and began to lift. I looked up and suddenly realized . . . I was standing at the foot of the Tyrolean Alps.

Awe-inspiring, to say the least,

and almost as though someone had arranged this scene for me...the local character, the foggy, overcast morning, and then. . . right on cue, the sky lightened and the picture emerged.

I stood there. . . just looking, for about thirty minutes.

or there are many side trips you can take on your own. . . you make up your own adventure! Of course, if you've been to Austria before, I needn't tell you of its magic.

The CMS tour includes seven days in Innsbruck, right in the middle of it all: the Tyrolean Alps, small-village charm, spectacular castles,



Innsbruck, Austria, 7:17 on a Saturday morning. Photo by Bill Pierson, CMS

Well, that's a taste of Innsbruck, and the reason I tell you all of this is to explain why I urged CMS to offer this kind of do-it-yourself tour. I said to myself "I'm going there. I'll see if there's really that much to see and do in and around Innsbruck". I did, and there is. CMS is participating in this inexpensive tour to Innsbruck through Arriva World Tours' "**Alpine Adventure**" and the tour price starts as low as \$699.00 (land only). When you arrive in Innsbruck, you can do as I did and just wander (open-mouthed, sort of gaping in wonder),

breathhtaking beauty. Nearby are Salzburg, Oberammergau, and Munich.

There's a trip going May 16-22, and another July 11-17, 1995. If you threw away the piece you received in the mail, it's not too late! Call Arriva, toll free: 1-800-697-5923.

You can see Venice/Mestre, wonderful northern Italy and Tuscany nearby, history and beauty at every turn. Or, you can extend your Austrian stay for six days in Munich. Join up... for a real **Alpine Adventure!** Oh, to be the tour-director!



Domestic Violence Resources - Coming in April

As many of you will recall, in 1991 CMS initiated a Task Force charged with developing a white paper on the role of physicians in the recognition, intervention and prevention of domestic violence. That role is an important one.

Your role as physicians, is not to cure domestic violence, but to recognize when it has occurred, treat the injuries and be a vital resource to your patients for information and referral to sources of further assistance.

A survey of Colorado Medical Society members (conducted by the CMS Family Violence Task Force) indicated that physicians need printed resource materials to assist them in providing the most effective response to their patients involved in domestic violence.

In April, physicians throughout the state will be receiving from CMS a packet of domestic violence related resource materials. These materials are being provided in an effort to facilitate your ability to be a patient advocate in this area and to intervene, to the best of your ability, with patients involved in domestic violence. Included will be 1) a poster which encourages patients to talk with their physicians if they are involved in domestic violence; 2) regional resource information cards for your patients, which indicate available shelters and other resources in your area; 3) a statewide resource referral list for you; 4)

office protocols; and 5) information outlining how to intervene with patients involved in domestic violence.

Physicians may be the first non-family member to whom an abused person turns for help. Studies have shown, however, that while physicians routinely see the consequences of violence and abuse, they often fail, for a variety of reasons, to recognize and acknowledge their etiologies. It is estimated that battered women may account for 1) 22%-35% of the women seeking care for any reason, in emergency rooms; 2) 23% of the pregnant women seeking prenatal care. One study found that physicians identified 1 in 35 of their female patients as victims of domestic violence when 1 in 4 were likely to have been abused.

While physicians can not solve this major social ill, you are in a unique position to contribute to the prevention and intervention in domestic violence and therefore be a part of the solution. We hope you will find the resource materials helpful in this endeavor.

We would like to thank the Copic Medical Foundation which supplied funding for the development and dissemination of these resource materials.

For more information, please contact Ellen Stein or Marilyn Barton at CMS (779-5455 or 1-800-654-5653).

9HEALTH FAIR

April 1 through 9 - 9HEALTH FAIR

1995 marks the 16th year 9Health Fair has provided basic health screenings and health education to citizens 18 years of age and over throughout Colorado and the Rocky Mountain region.

Free screenings at more than 100 sites consist of height, weight, blood pressure, vision, and colorectal.

An optional twenty-nine component blood chemistry analysis, including a coronary risk ratio, is available for only \$25. Men may take advantage of the prostate cancer screening through the blood chemistry for a nominal fee of \$15.

Additional screenings of hearing, glaucoma, oral cancer, foot, body fat composition, breast exam, pap smear, body in balance, peripheral vascular disease, prostate and testicular cancer and skin cancer examinations are offered at various sites throughout the state.

At selected sites childhood immunization clinics will be offered in partnership with Colorado Rotary Clubs. Rotary looks forward to immunizing 5,000 preschool children at these sites against polio, measles, mumps, meningitis, diphtheria, whooping cough, tetanus, tuberculosis, and hepatitis B.

9Health Fair, a non-profit organization, is the only fair endorsed by the Colorado Medical Society.

SYPHILIS ADVISORY

The incidence of early syphilis (primary, secondary, and early latent) has increased in Colorado during the past two years. The vast majority of these cases are in the Denver metro area. Congenital syphilis, which is the most important sequelae and the result of infected pregnant women going untreated or being inadequately treated, has increased during this time as well.

Syphilis should be considered in the differential diagnosis of any sexually active person presenting with the signs and symptoms described below.

SYMPTOMS TO WATCH FOR

The incubation period for syphilis is usually three weeks, but ranges between 10 and 90 days. Patient use of certain medications, such as antibiotics, may cause delays in the appearance of symptoms. Periods of latent disease (by definition, the absence of symptoms) occur between the primary and secondary stages, between recurring secondary stages, and after the secondary stage.

Primary Syphilis

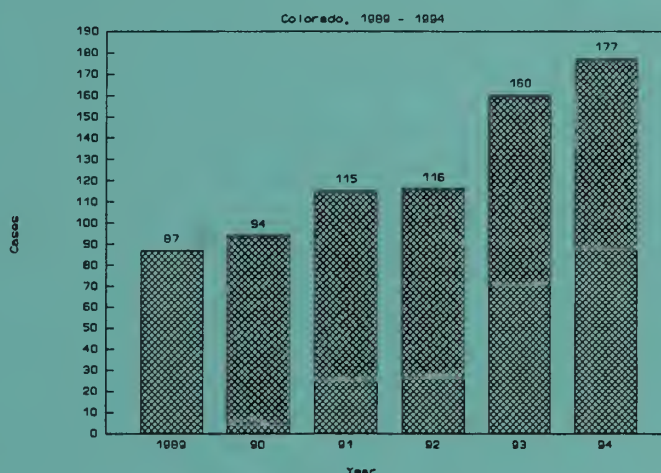
Typically, the first stage (primary) of syphilis is marked by the appearance of a single, small, painless ulcerated lesion. Because syphilis can be transmitted through all types of sexual activity, lesions may be located in or around the genital region, mouth, or anus. Multiple primary lesions have also been observed, and some may be as large as the size of a quarter. Some patients may mention "a pimple", a "paper cut", or possible zipper injury that lasted one to three weeks. A primary lesion may be painful, especially in the presence of a secondary bacterial infection or if the patient has made attempts to self-medicate. Many primary symptoms go unnoticed and all will disappear after about three weeks, even without treatment.

Secondary Syphilis

The secondary stage of syphilis commonly produces rashes on the hands and/or soles of the feet as well as the whole body, condylomata lata (flat, raised papules), "mucous patches" (mucosal ulcers), lymphadenopathy, and/or alopecia. A recurrence of secondary signs and symptoms may appear in untreated patients up to four years after infection, although most will occur within one year. Syphilis can be transmitted at any time while symptoms are present, even if they are not clearly visible.

Any of the above described signs should raise the index of suspicion, indicating the need for serologic tests. **Treatment is recommended before test results are confirmed for all probable cases (even if a dark-field microscopic exam is negative) and for all sex partners of early syphilis patients who could have been exposed to the disease.** This is especially crucial when follow-up testing and treatment cannot be assured. Remember: syphilis is known as "the great imitator". A number of recent cases have been misdiagnosed. Therefore, when in doubt, test and treat. Also, genital ulcers have been shown to facilitate HIV transmission, therefore, people with syphilis should be counseled and offered HIV testing.

Reported Cases of Early Syphilis



RECOMMENDED DIAGNOSTIC TESTS

Serologic tests for syphilis (STS) are readily available through public and private laboratories. An RPR test and an FTA test should be ordered in all suspected cases of syphilis. An RPR alone is sufficient for general screening. Dark-field microscopic examination of suspicious anogenital lesions is available at the Denver Metro Health Clinic, 605 Bannock Street, Denver (call 436-7250 for questions or to make a referral). For the diagnosis of congenital or neurosyphilis, CSF testing (VDRL and FTA on request) is available at no charge through the state laboratory. Serologic tests can be negative for up to 10 days after the onset of a lesion, therefore public health authorities recommend treatment based on clinical signs when follow-up testing and treatment cannot be assured.

RECOMMENDED TREATMENT

For cases of early syphilis (primary, secondary, and latent syphilis of less than one year's duration) and sexual contacts to early syphilis, the recommended treatment is 2.4 million units of Benzathine penicillin (1.2 million units into each buttock) by intramuscular injection at a single session. For patients allergic to penicillin, Doxycycline 100mg b.i.d. x 14 days or Tetracycline 500mg q.i.d. x 14 days are indicated. For pregnant women who are allergic to penicillin, desensitization and treatment with Benzathine penicillin is the only recommended treatment option. (CDC, 1993 Sexually Transmitted Diseases Treatment Guidelines. MMWR 1993;42[RR-14]:27-46).

SCREENING

Routine syphilis screening is required by law for pregnant women and recommended during the first and third trimesters. Screening is also recommended for patients with any STD symptoms and those who report multiple sex partners. Patients who are HIV infected should be screened for syphilis as part of their initial evaluative exam.

REPORTING

Prompt reporting of syphilis to public health officials ensures more effective application of investigative and disease control methods and early intervention. The Colorado Board of Health requires that all cases of early syphilis be reported to the Colorado Department of Public Health and Environment (CDPHE) or your local health department within 24 hours of diagnosis. Reports should include the patient's name, date of birth, sex, address, and phone number as well as the physician's name, address, and phone number. To report a case call 1-800-866-2759 or (303) 692-2700 or call your local health department.

PARTNER NOTIFICATION AND PATIENT COUNSELING

In cooperation with health care providers, the Field Services Program at CDPHE conducts follow-up investigations on all positive syphilis reports to ensure proper education and counseling of patients as well as the confidential notification, testing, and treatment (when appropriate) of their sex partners. This is designed to prevent complications and the spread of disease. We are especially concerned with the prevention of congenital cases.

QUESTIONS AND ASSISTANCE

If you have questions and/or need assistance concerning treatment guidelines, interpretation of blood test results, staging syphilis cases, managing suspected cases, and/or partner notification, or if you need further information, please call the CDPHE - Field Services Program at 692-2760 or the Denver Metro Health Clinic at 436-7250. For additional copies of this advisory, please call 692-2760.



CMS Members Elected to Blood Center Foundation

Four Colorado physicians have been elected to the newly established Bonfils Blood Center Foundation. They are Ben Galloway, M.D., associate director of laboratories at Denver General Hospital, Stuart Marsh, M.D., pathologist at Parkview Episcopal Hospital in Pueblo; Richard C. Olshock, M.D., of Denver's Lutheran Medical Center; and Osgoode S. Philpott, Jr., M.D., son of one of the founders of Bonfils Blood Center.

Blood Center Medical Director/President/CEO William C. Dickey, M.D., was appointed president/chief executive officer of the Foundation. Tom Puckett, administrator/chief operating officer of Bonfils Blood Center, serves as an ex officio member of the board.

The Foundation was recently created to assist Bonfils Blood Center, a statewide nonprofit organization, with funding projects and programs that will enhance current and future activities of the Blood Center. The Foundation will also assist with community education and outreach.

The Foundation's activities this first year include funding efforts for a capital project to relocate the Blood Center from its two current operating and support centers in Denver to the former Lowry Air Force Base Commissary and funding for the state's first bloodmobile. Bonfils Blood Center provides more than 70% of the state's voluntary blood supply.

Vocational Rehabilitation Leaflet

A new Social Security leaflet is designed to raise public awareness of the services available for people with disabilities who can benefit from vocational rehabilitation, Social Security Manager Tom Przytarski, said.

"Many people don't realize that Social Security is involved in helping to provide vocational rehabilitation services to people with disabilities," Przytarski said. In fact, we have a partnership with State vocational rehabilitation services that recognizes that there is a direct connection between Social Security disability benefits and services that can help people who wish to go back to work," he said.

Przytarski said Social Security refers all disability applicants to State vocational rehabilitation services who appear likely candidates for rehabilitation. Social Security pays for the services to disabled beneficiaries who are successfully rehabilitated, he said. The availability of such services is likely to increase due to the recent passage of a law that permits beneficiaries to use private providers as well as state providers of services, Przytarski said.

Copies of the leaflet are available from any Social Security office, or by calling 1-800-772-1213. Ask for the leaflet "How Social Security Can Help with Vocational Rehabilitation," SSA Publication No. 05-10050.

X-Ray Operator Rules

The Colorado State Board of Medical Examiners (BME) issued regulations which become effective July 1, 1995 requiring unlicensed X-Ray operators to pass a limited scope examination before operating X-Ray equipment in physicians' offices. This basically means that only a physician, a Registered Radiologic Technician or someone who has passed that test will be allowed to operate X-Ray equipment outside of a hospital setting. Susan Miller, Program Administrator of the BME, says that the Attorney General's office has informed them that nurses and other allied health personnel will not be allowed to operate X-Ray equipment in a physician's office, even as a delegated medical function, without passing the examination.

In addition, the physician will shoulder virtually all of the liability for any problems arising from operation of X-Ray equipment by persons in his or her employ. Tom Beckett of Copic Insurance, Colorado's largest malpractice insurer, says that, under the terms of the Medical Practice Act, the physician is "Captain of the Ship" and therefore responsible for anything that happens to patients in the practice, especially acts done by persons employed by the physician.

Unlicensed X-Ray operators must pass the test or stop operating X-Ray equipment after July 1, 1995. Contact the BME for details at 303-894-7690.



Birth rates decline in Colorado

Births in Colorado fell from 54,525 in 1992 to 54,013 in 1993, according to the Women's Health Section of the Colorado Department of Public Health and Environment. During the same time period, women in the state of Colorado between the ages of 15 and 44 increased. In addition, the general fertility rate, the number of births per 1,000 women of childbearing years, fell 2.5 percent.

The overall fertility decline is due primarily to decreases in fertility among women under the age of 25. Among women age 20 to 24 the fertility rate dropped from 117.6 per 1,000 in 1992 to 109.3 in 1993, a decline of 7 percent. This is the sharpest one-year decline in over twenty years. The decline was found in both the rate of first and second births.

Most notable, the teen fertility rate (ages 15-19), which increased by 18 percent between 1984 and 1991, fell both in 1992 and 1993. The overall decline was 7 percent in two years. The declines are concentrated in a reduction of second and higher order births to teens.

"We are currently conducting further analysis to determine what has caused such a significant reduction in the birth rate", said Joan Henneberry, director of the Women's Health Section.

For more information on teen pregnancy, fertility rates and pregnancy prevention programs, call the Colorado Department of Public

Health and Environment at (303) 692-2480.

Domestic Abuse tax check-off campaign

Donations help Colorado victims of Domestic Violence

The Domestic Abuse Assistance Program (DAAP) is asking all Colorado taxpayers to participate in their annual tax check-off campaign to benefit Colorado victims of domestic violence.

The check-off process is simple. Taxpayers who prepare their own returns simply check the DAAP box and indicate the amount they wish to contribute. Those who have their taxes prepared by a professional, only need to request that their preparer do the same.

"More and more people are now coming forward to get out of abusive relationships," said Janet Mickish, executive director of the Colorado Domestic Violence Coalition. "A successful tax check-off campaign is critical for the Domestic Abuse Assistance Program to continue providing the services and help that victims need."

For additional information on the tax check-off, call 573-9018.

Dr. Hoehn elected President of two medical Societies

Robert J. Hoehn, M.D. F.A.C.S., has recently been elected president of two Medical Societies.

The Denver Medical Club, a 100 year old organization whose mem-

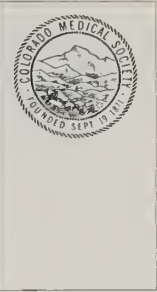
bers largely are drawn from the ranks of the Denver Presbyterian and St. Luke's medical staffs. This is a medical study group, composed wholly of physicians, whose dinner meetings are held once monthly at the University Club.

The Rocky Mountain Association of Plastic and Reconstructive Surgeons, a group whose membership consists solely of plastic surgeons all of whom are certified by the American Board of Plastic Surgery following rigorous training residencies in both general surgery, or its equivalent, and in plastic, reconstructive and hand surgery. All the states of the Rocky Mountain West are represented in the membership and their annual meetings are devoted to the presentation and discussion of mutual and current issues in the specialty of plastic and reconstructive surgery.

Dr. Hoehn is also clinical Professor of Surgery (Plastic Surgery) at the University of Colorado Health Sciences Center.

Orthopaedic Fellowship Offered

Orthopaedics Overseas, a private, voluntary organization seeking to effect a long-term improvement in the quality of medical care delivery in developing countries, is offering a fellowship to an orthopaedic surgeon who completed training after January 1, 1994. The Fellow will receive up to \$2,500 to cover the cost of transportation and living expenses and will be sent to an Orthopaedics Overseas site to be involved in the teaching of local medical personnel



in both clinical and didactic settings.

For more information, contact Orthopædics Overseas at 202-296-0928 and ask about the Zimmer Fellowship.

Vital Record Fee Increase

The fee for a single certified copy of a vital record will increase from \$12.00 to \$15.00 effective 1 March 1995. The fee for additional copies of the same record purchased at the same time will remain at \$6.00 each. The fee increase applies at the State Vital Records Office and at all County Registrar Offices. Vital record fees in Colorado were last increased in November, 1990.

The fee to process corrections to records, court ordered name changes, decrees of adoption, court ordered or voluntary paternity acknowledgements, and delayed birth or death records will also increase. The increase in the fee for processing these records will be from \$15 to \$20. All other fees will remain unchanged.

The State Vital Records Office, located at 4300 Cherry Creek Drive South in Denver, can issue certified copies for births occurring anywhere in Colorado from 1910 to the present.

For more information about vital record fees or services of the State Vital Records Office, please call (303) 756-4464 for a recorded message.

Health Board to Consider Amendments

On April 19, 1995, the Board of Health will consider amendments to the Regulations Pertaining to Epidemic and Communicable Disease Control. Public testimony will be taken. The amendments consist of: 1) the addition of invasive group A streptococcal disease to the list of conditions which must be reported by physicians, healthcare providers and laboratories, and 2) the modification of procedures for investigating epidemic and communicable diseases to include obtaining lists of persons, travelers and passengers who have had a similar exposure to a reported case, surveying of exposed persons, examining exposed persons with their consent, collecting environmental specimens, and conducting investigations in workplaces, including taking photographs, if necessary, pertinent, and relevant to the investigation.

The Board requests submission of written materials at least seven days prior to the hearing to allow the Board sufficient time to review the comments prior to the meeting. Persons wishing to submit written comments or views should submit them to:

Colorado Board of Health
ATTN: Linda Shearman, Staff Assistant
Colorado Department of Health
4300 Cherry Creek Drive South
OEA-A5
Denver, CO 80222-1530

The hearing will be held in the Sabin Conference Room of the Colorado Department of Health, Bldg. A., First Floor. Call 303 692-2025 on or after April 7 for the exact time of the hearing.

Dr. Apgar honored in Colorado legislature

On Friday, March 17, the Colorado Legislature, through a Senate Joint Resolution, honored Dr. Virginia Apgar. Dr. Apgar was both a visionary and a pioneer in anesthesiology, perinatology and teratology.

In the late 1940's, the APGAR score, which is used to assess the condition of newborns and determine the need for any life saving assistance, was developed. In 1962, Dr. Joseph Butterfield, a Colorado Pediatrician, CMS member, and March of dimes volunteer, created the acronym named after Dr. Virginia Apgar.

A- Appearance of skin and mucous membranes

P- Pulse

G- Grimace (reflex irritability)

A- Activity

R- Respiratory effort

Today this score is used on every newborn baby in modern hospitals throughout the world. In 1993, through the efforts of Dr. Joseph Butterfield, the U.S. Postal Service honored the efforts of Dr. Apgar by inducting a Virginia Apgar twenty cent stamp, in the Great Americans Series, to succeed President Harry S Truman.



Cancer Prevention Efforts

Breast Cancer Prevention Trial Resumes Enrollment

Participant enrollment for the Breast Cancer Prevention Trial has resumed at seven Denver area hospitals and one Colorado Springs.

The study, which opened in the spring of 1992, is designed to determine whether taking the anti-cancer drug tamoxifen will prevent the development of breast cancer in women at increased risk for the disease.

Women over the age of 35, who are at increased risk for breast cancer due to family history and/or other factors, may obtain more information about the Breast Cancer Prevention Trial by calling the Colorado Cancer Research Program at (303) 777-2663.

Several Metro area hospitals will take part in a Landmark Prostate Cancer Prevention effort

The study will determine whether taking the drug finasteride can prevent prostate cancer. To be eligible for participation in the trial, men must be at least 55 years old, in good health, and without evidence of prostate cancer. The 18,000 men will be divided randomly into two groups. Half will take finasteride pill daily for seven years, and half will take a placebo. All participants will be followed closely with examinations and blood tests. The two groups will be com-

pared to see whether their prostate cancer rates differ.

For information, contact: Colorado Research Program, (303) 777-2663.

Rose starts multi-faceted approach to sports medicine

The Rose Health Care System has announced a new, multi-disciplinary sports medicine program, headed by Wayne K. Gersoff, MD and Andrew Parker, MD, both CMS members. Dr. Gersoff says, "We've created a

comprehensive approach which allows for the most personalized patient care. As a result, Rose Sports Medicine provides access to a wider range of specialists in other medical and surgical areas related to sports medicine."

Orthopaedic surgeons and internal medicine specialists will work together on the program, which will address all levels of sports medicine, addressing such issues as nutrition, sports psychology, diabetes, asthma and pregnancy, among others.



A child cries for food. We doctors must answer.

World hunger is an ever-present scourge that claims 35,000 lives each day.

Physicians Against World Hunger (PAWH) is a non-profit, tax-exempt organization, founded by physicians to defend the basic human right to food. In partnership with well recognized and reputable organizations PAWH supports hunger projects throughout the world.

Together physicians must bring an end to world hunger. We are sworn to protect human life. When people dying of hunger cry out for help, we must respond. Please join us.



Physicians Against World Hunger

#2 Stowe Road, Peekskill, NY 10566 (914) 737-8570

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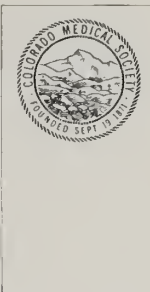
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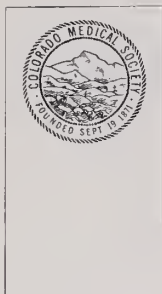
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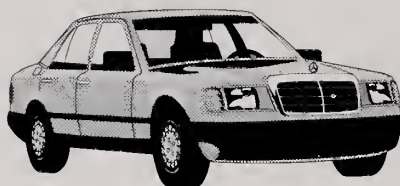
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Colorado Medical Society



(def: chewing again what has been chewed slightly and swallowed; to REFLECT)

by **Bill Pierson**, Managing Editor

Do not misunderstand me; I am not admitting an erroneous conclusion, but I am saying that there is always more than one right answer to just about every question.

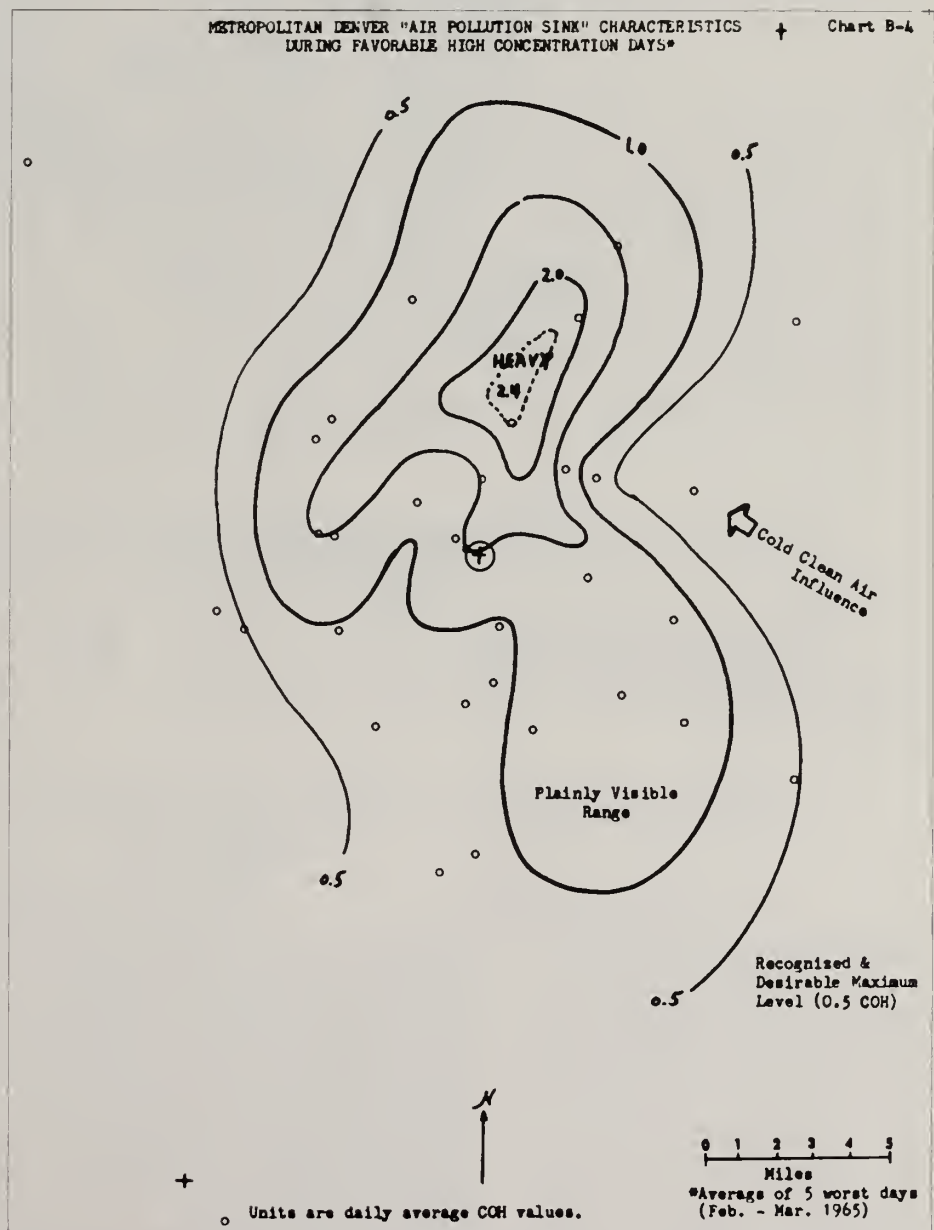
Wait! Change that to "more than one acceptable answer..." I have just today accepted this newly-worded old philosophy. I was saying "right", but am I to judge "right" from something else?

Last month, I bemoaned the fact that our dreams of the great sports mega-capitol were coming true in the Platte River Valley of metropolitan Denver. I still bemoan that fact, but not for precisely the same reasons this month. I said that studies have shown that the location of Coors Field was precisely the core center of Denver's worst air pollution, and that is true; we proved it in a Health, Education and Welfare sponsored study in 1965-66. The center so clear **we even called it** the "Air Pollution Sink" (Chart B-4). If you look carefully at the chart, you'll see the most severe pollution in an average of the five worst days in February, 1965 (Chart B-5), was centered at the Denver Sewage Treatment Plant, E. 50th and the Platte River. That's less than a mile from the Coors Field parking lot.

The pollution cloud then stretched upstream -- to the south -- and the second-worst concentration was centered over West Third Avenue at Platte River.

The 1965-66 study found very early that Denver was built in a bowl, the Platte River carves its way through the bottom of the bowl, and everything flows down into that bottom. What the study also handily discovered was that if you watch the

"One thing I've learned: keep an open mind, if for no other reason than to adjust to your own erroneous conclusions."



cloud of polluting particulate over a 24 hour period it did not dissipate; instead, it rather undulated up and down the valley, sometimes spreading out along Clear Creek and Coal Creek to the northwest toward Boulder, and along Sand Creek to the east from Commerce City, the long

You could see the entire Valley from horizon to horizon. Anyway, my job was to see what happened to that cloud and see if the particulate monitoring stations were telling us the truth. The full moon gave the pollution cloud a luminous, silvery, ghostly quality; I was equivalent of

days, the cloud would break the banks and overflow the river valley, spreading east and west and covering the city in a dirty, cottony blanket.

All these things I have said are true, but there is a factor that may change my argument:

All studies of Denver air pollution indicate the worst occurrences are November through early March. Since the baseball season does not commence until April (excluding consideration of spring training, which is someone else's pollution problem), the heaviest concentration of automobile traffic will not occur until after the worst of the season is over. I admit I forgot that one factor.

So, until baseball club owners decide to extend the season on either end, I guess we are safe. We can now relax and hope for continually blustery days so that the pollution, though not visible or hugging the ground, will be blown on into Weld County and beyond. We just won't have to worry about it.

It is equally fortunate that Elitch Gardens amusement park will only be open from May to September, once again carefully keeping the concentration of fun-seekers in the "non-air polluting" months.

Since football and basketball have both been played in the valley for a lot of years, I guess we won't worry about them. Then, too, if the football season is not extended, the number of home games is limited to fewer than ten or so. As a result, the pollution is rather spotty. Most of the basketball games are played at night. Not many people notice pollution after dark.

No one paid much notice to this study or this report, which date back 30 years. The valley and air masses have not changed; there is a new addition: starting in the middle of March there has been a daily profusion of aircraft constantly circling over downtown, boasting the opening of Coors Field, **and** boosting air and noise pollution to the valley.

Granted, none of my newfound answers is necessarily scientifically correct or factual, but they seem to be acceptable to those who have been planning this valley sports and entertainment colossus.

PHOTOGRAPHIC DOCUMENTATION OF SEVERE AIR POLLUTION
OVER METROPOLITAN DENVER - February 2, 1965, 2 PM

† Chart B-5



Note:
Lines of Air Pollution Concentration
Based Upon Air Sampling Data From
Ground Level Instrumentation. (COH's)

tendrils moving along in waves, or lying low, clinging to the ground surface. As the winds shifted when the sun went down, the cloud would gather itself and go upstream, most nights all the way to Littleton.

I can still remember one winter night, a full moon, and I was up in the Daniels & Fisher Tower at 16th and Arapahoe. In those days, there was scarcely anything in your way.

30 stories in the air. I actually saw the cloud move south over Littleton, and when the winds shifted with the early morning cooling, the cloud stretched itself out along the river, almost like some ghostly animal coming out of its lair and slither along the valley (and "Valley Highway") and when the sun came up it was all in place, hiding out in the bottoms.

On the extremist of the extreme

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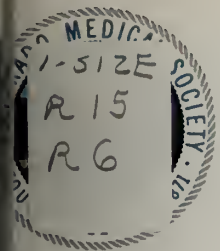
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June, 1995

Volume 92, Number 5



Rural Health: Riding the Rapids of Change

Colorado Rural Health Conference • June 15-17 • Cañon City, Colorado

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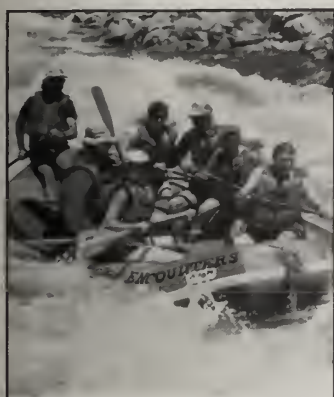
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May, 1995

Volume 92, Number 5

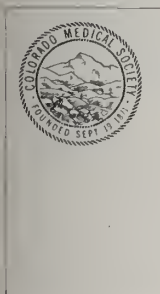


Cover Story

Riding the white water of medical practice in a rural area can be both fulfilling and challenging. See Page 165 for more...

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by **Montgomery Little and McGrew, P.C.**

legal counsel to the Colorado Medical Society

CMS In Tune

As I sat on the dais this past weekend at the Interim session of the CMS House of Delegates, I was amazed at what was happening. Over the past 17 years that I have attended these meetings, I have survived the debates regarding the founding of Copic, the "Building" fiasco, and the civil war between Denver and the rest of the state, but I have never, until now, seen a meeting with no controversy at all. Other than routine "sunsetting" resolutions to clean up the policy manual, there was one resolution for each of the Reference Committees to consider, both submitted by CMS councils. There were no resolutions from the component societies, individual members nor any late resolutions. (Where was Bernie when we needed him?) The resolutions did not generate any opposition at all in the Reference Committee sessions which were well attended. The only changes made were small corrections of grammar to clarify meaning. When they reached the floor of the House, NOT ONE person came forward to testify for or against the resolutions and the House of Delegates completed their business in Guinness reportable record time.

What is the significance of this? Are the members uninterested and apathetic or have they just given up and lost hope? I think the opposite. The membership of the CMS is at a record high. Donations and membership on COMPAC are also at a record high. These figures do not suggest apathy. Sitting in the meetings of the Board of Directors, and listening to the presentations of the leadership on the "State of the Society", it is obvious that a big change has occurred. The leadership, primarily the President and President-Elect, have placed the control of the society back into the hands of the entire Board. Instead of pushing an agenda that is imperative, the leadership is responding to the membership through the board and anticipating problems so that the society can deal with them before they become critical issues. They are not just testifying before the legislature, but personally lobbying all of the important

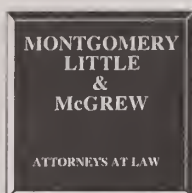
by Stuart Silverberg, MD, Clear Creek Valley
(reprinted from the Clear Creek Valley Medical Society Newsletter)

players on a one to one basis. As a result, the Board members are more enthusiastic and are communicating with their components. What happened this weekend reflects a greater satisfaction with what the officers and board are doing to head off highly controversial issues by conciliatory approaches. They are working overtime to promote the programs that the members have selected as important.

In summary, the Colorado Medical Society is at this time, more in tune with the membership than I have ever seen in the past 17 years that I have served as delegate and Vice Speaker/Speaker of the House. I would like to commend all of the Officers, the administrators, the Councils and all of the Delegates for a job extremely well done. Clear Creek can be proud of our President-Elect, Joel M. Karlin, MD, for the role he has taken in accomplishing this positive change for the Colorado Medical Society and all of the physicians in Colorado.

Cover Note

Dr. Jack Berry, Chairman of the CMS Rural Health Task Force, has been placed in charge of riding the rural health rapids on our cover this month (the one with the oars). Dr. Berry stresses the importance of rural health professionals working together to insure the best health care for all Coloradans. Dr. Berry is also an experienced white water rafter.



Med Fax: Medico-Legal News

by Karen B. Best, Esq., an associate
with the law firm of Montgomery Little &
McGrew, PC.

*This column is not legal advice, but is
for general information only. For help with specific problems,
readers should consult an attorney.*

OBRA 1993 & Stark II

by Michael H. Smith, Montgomery Little & McGrew, PC
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More Exceptions...

(continued from last month)

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Public Companies

A physician will not be precluded from referring patients to an entity if his or her only financial relationship with the entity stems from the ownership of investment securities in a corporation which may be purchased on terms generally available to the generally available to the public and which are traded on public exchanges. To qualify for this exception, the corporation must have stockholder equity exceeding \$75,000,000. Similar rules apply to ownership in mutual funds.

This stockholders' equity test is more stringent than the asset test contained in the investment interest safe harbor under the Anti-Kickback Statute. Since few health care corporations have stockholders' equity of such a magnitude, this exception is not likely to be of much practical value. Moreover, Stark II has no analogue to the 60/40 test for investment in small businesses that appears in the safe harbor provisions. Thus, for the most part, physician ownership of and referral to freestanding diagnostic clinics and other similar facilities that are not operated by an organized group practice will be strictly prohibited once Stark II takes effect.

Hospitals in Puerto Rico

Stark II retains the exception crafted under Stark I relating to ownership or investment in hospitals in Puerto Rico.

Rural Providers

Rural providers of designated health services continue to receive favorable treatment under Stark II. The definition of an "ownership or investment interest" does not include such interests in an entity located in a rural area if substantially all the designated health services furnished by the entity are furnished to individuals residing in the rural area. A rural area is an area outside the Metropolitan Statistical Area as defined by

the Office of Management and Budget.⁵ Reliance on this exception will require tracing the residence of the entity's patients and will depend on the meaning of "substantially all," an undefined term.

Hospital Ownership

Ownership or investment in a hospital (but not merely a subdivision of the hospital) will not constitute an ownership or investment interest for purposes of Stark II if the referring physician is authorized to perform services at the hospital.

Exceptions Relating to Compensation Arrangements

Stark II lists eight categories of compensation arrangements which will not be considered financial arrangements within the meaning of the statute. These exceptions generally include some subjective criteria, such as "reasonableness" and "fair market value." The exceptions described in the statute are discussed in the following subsections.

Rental of Office Space or Equipment

Stark II's exception for rental of office space or equipment largely parallels the safe harbor provision applicable to the same kind of arrangement, although the Stark II exception contains certain added requirements. In order for referrals between a lessor and lessee to be permissible, Stark II requires that the space or equipment being leased not exceed that which is necessary for the "legitimate business purposes" of the arrangement.

The space or equipment must be used exclusively by the lessee when being used by the lessee (except that space leases may make provisions for use of common areas under certain specified terms), and the arrangement must be commercially reasonable even if no referrals were made between the parties. Lease arrangements which have been structured to satisfy the safe harbor provisions also should be able to satisfy these additional criteria for exemption under Stark II.

Personal Service Arrangements

The Stark II exception for personal service arrangements loosely corresponds to the personal services and management contracts safe harbor under the Anti-Kickback Statute. The Stark II provision does not use the "principal/agent" language contained in the safe harbor and appears to provide protection to many of the physician-independent contractor relationships common in the health care industry, particularly in states such as Colorado that continue to apply the corporate practice of medicine doctrine.

Although compensation paid under the arrangement generally may not take into account the volume or value of referrals, an exception has been included for physician incentive plans that include such things as withholds, capitation arrangements and bonuses which may be paid based on the volume or value of referrals,

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if the plan meets certain statutory criteria.

Bona Fide Employment Relationships

Stark II necessarily excepts from the definition of compensation arrangement amounts paid to a physician or his or her immediate family member pursuant to a *bona fide* employment relationship. The statute does not expressly incorporate the Internal Revenue Service definition of employee, although it is likely that definition will be relied on by the Secretary of HHS, if and when final regulations are adopted under the statute.

As in the personal service exception, discussed above, the compensation must be consistent with fair market value and must not be determined in a manner that considers the volume or value of referrals (although productivity bonuses are permissible). The Stark II employment exception is thus considerably narrower than the parallel safe harbor under the Anti-Kickback Statute.

Physician Recruitment

Hospitals that provide recruitment packages to physicians relocating to the hospital service area may accept referrals from those physicians without violating Stark II as long as there is no requirement to refer and the compensation is not based on the volume or value of referrals. Recruitment packages to new physicians already situated in the hospital's service area appear to be problematic. It will be interesting to see whether this exception—substantially broader than the proposed safe harbor relating to physician recruitment—will be narrowed when final regulations are promulgated under Stark II.

Other Payments from Hospitals

Remuneration unrelated to the provision of designated health services and remuneration relating to a group practice's provision of certain inpatient services under arrangements with a hospital will not trigger the referral prohibitions of Stark II. The former of these exceptions is important, for example, to physicians who are compensated for the provision of administrative services to hospitals.

Isolated Financial Transactions

Transactions such as a one-time sale of property or a practice, at a fair market price determined in a manner that does not take into account the volume or value of any referrals and which transaction would be

commercially reasonable even if no referrals were made, are not considered compensation arrangements under the statute. This exception may pose a trap for the unwary in the case of an installment sale. As long as the entity providing designated health services owes a debt to the physician, the physician will be considered to hold an investment interest in the entity,⁶ unless another exception applies.

Physician Payments for Items and Services

The final exception to the definition of a compensation arrangement applies to payments by a physician to a laboratory for clinical laboratory services or payments to an entity for other items or services furnished at fair market value. Without this exception, a literal reading of Stark II might prohibit a physician from purchasing designated health services from an unrelated entity and paying that entity for its services, to the extent otherwise permitted under applicable reimbursement rules, for use in the provision of care to Medicare and Medicaid patients.

Conclusion

The development of new and unique relationships between physicians and other health care providers in today's environment of health care reform greatly increases the potential application of Stark II. The creation of new delivery systems will require careful analysis to ensure compliance with Stark II, both with respect to the formation of the system and the creation of continuing compensation arrangements as the system operates. It remains to be seen whether any regulatory scheme finally promulgated under Stark II will further tie the hands of health care providers as they struggle to provide innovative and effective means to compete in this dynamic environment.

Note: Physician ownership and self-referral prohibitions were expanded under OBRA 1993

*by Karen B. Best, Esq. an associate with the firm of
Montgomery Little & McGrew, PC.*

"Stark II" greatly expands anti-referral laws prohibiting physicians from referring patients for certain designated Medicare and Medicaid covered services to an

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entity with which the physician has a financial relationship. Although the law went into effect on January 1, 1995, questions about the meaning and effect of certain terms contained in the statute have stalled its enforcement. Some of those questions relate to the definitions of fundamental terms such as "financial relationship," "compensation arrangement," and "group practice." The article by Mike Smith, Esq., printed elsewhere in this publication, refers to certain exceptions to the prohibition against referrals, which carry with them detailed requirements. However, the lack of precision with respect to those exceptions must be eliminated before enforcement commences. Until regulations are published clarifying the terms, clarifying the nature and scope of the relationships intended to be effected by the law, and clarifying the intended impact upon the practice of medicine, healthcare counsel can only make educated guesses about the statute's meaning.

Nonetheless, Stark II so broadly refers to referrals, and so severely sanctions physicians for infractions, that it is incumbent upon physicians to familiarize themselves with the law in general, lest they unwittingly violate its terms.

On its face, "Stark II's" scope is comprehensive: It applies not only to physicians, but also to osteopaths, oral surgeons, dentists, podiatrists, optometrists and chiropractors, as well as to members of their immediate families.

Although the prohibitions under Stark I applied to clinical laboratory services only, Stark II extends to a long list of other "designated services" including: physical therapy; occupational therapy; radiology services, including magnetic resonance imaging computerized axial Tomography scan and ultrasound services; radiation therapy; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

The prohibition against referral is triggered, with some exceptions, by the existence of a broad range of ownership or investment interest can be in the nature of equity such as shares of a corporation or partnership interests, or debt such as notes or bonds, or "other

means." A "compensation arrangement" is defined to include any remuneration, including compensation paid to physicians for services rendered, payments for renting space or equipment, royalties, and licensing fees, and may also include discounts from retail prices on sales of goods and services. Significant questions remain about what constitutes an ownership or investment interest and a compensation arrangement.

Penalties under Stark II are severe and may include denial of payment for services rendered as a result of a prohibited referral, civil monetary penalties, and exclusion from Medicare and Medicaid programs.

Stark II will likely affect nearly every healthcare provider to some extent. Both existing and contemplated financial relationships will have to comply with Stark II's terms and its clarifying regulations, and that compliance may require a restructuring of existing financial relationships and structuring of anticipated financial relationships to conform with the requirements of Stark II. Attorneys at Montgomery Little & McGrew, P.C., are familiar with Stark II and are prepared to counsel physicians concerning the intricacies and the application of the statute to their practices.

¹ Pub. Law No. 103-66, 107 Stat. 596 (1993).

² Social Security Act § 1128B(b); codified at 42 U.S.C. § 1320a-7b(b).

³ Pub. Law No. 103-66, § 13562. Stark II was originally introduced by Rep. Fortney Stark of California as a separate bill but was subsequently incorporated into OBRA 1993.

⁴ Final regulations at 42 C.F.R. § 1001.952 et. seq. list eleven safe harbors. Seven new safe harbors have been set forth in proposed rules published Sept. 21, 1993, at 58 Fed. Reg. 40,008.

⁵ 42 U.S.C. § 1395ww(dx2xD).

⁶ Preamble to proposed regulations, 57 Fed. Reg. 8588 (March 11, 1992).

OSHA Requires That Employers Exhibit Poster #2203

Poster #2203, which provides information on the Occupational Safety and Health Act of 1970, must be placed in a conspicuous area where notices to employees are customarily posted. Call your local OSHA office to obtain the poster.

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- What do I do if I can't get insurance coverage?
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Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Advisory Council on Health Programs for Women and Children

Regular monthly meeting.

For information call Suzette Clark at (303) 692-2421.

Colorado Health Services Marketing

"Integration: Market Forces and Critical Success Factors"

Friday, May 19, 1995

Denver, CO.

Marriott Denver Tech Center

Contact: Fontera & Assoc. at (303) 674-5269

Colorado Society of Osteopathic Medicine

Annual Meeting

June 16-18, 1995

Snowmass Conference Center, Snowmass at Aspen, Colorado

Contact: Patricia Ellis (303) 322-1752

Montgomery Dorsey Symposium

Fifteenth Annual Montgomery Dorsey Symposium "The Fate of the American Health Care System: Perspectives from Key Players"

July 27-29, 1995

Beaver Creek, Colorado

Contact: (303)322-1523

American College of Cardiology

Echocardiographic Symposium of 2-D and Doppler Echocardiography at Vail

July 31-August 3, 1995

Marriott's Vail Mountain Resort, Vail, Colorado

CME credits: 23 Category 1 AMA

Contact: 800-257-4739, FAX 301-897-9745

International Meniere's Disease Research Institute

8th Annual Electrocochleography/Otoacoustic Emissions/Intraoperative Monitoring Seminar, August 2-6, 1995 Denver, CO.

Contact: Jane Wells or I. Kaufman Arenberg, MD.(303)778-4235

American Association of Blood Banks

Ensuring a Predictable Donor Base: Marketing Models for the 21ST Century

September 10-12, 1995

Hyatt Regency Denver, Denver, CO.

Contact: (303) 295-1234

American Society for Medical Technology

Intermountain States Seminar, "Renewal of Excellence".

September, 13-16, 1995

Jackson, Wyoming

Contact: Mary L. Minish, IMSS Publicity Chair, P.O. Box 3778, Jackson, WY. 83001

Commission on Family Medicine

1995 Opportunities Fair, "Your chance to recruit physicians from the ten Colorado Family Residency training programs.

September 22-24, 1995

Copper Mountain Resort

Contact: (303)745-4275

Denver Medical Library

Third Annual Medical Informatics Fair

September 28-29, 1995.

1719 E. 19th Street, Denver, CO

Contact: The Denver Medical Library at (303) 839-6670

International Meniere's Disease Research Institute

7th Annual Interdisciplinary Seminar on Diagnostic and Rehabilitative Aspects of Dizziness and Balance Disorders.

December 6-10, 1995, Denver, CO.

Contact: Jane Wells or I. Kaufman Arenberg, MD.(303)778-4235

American Brachytherapy Society

Annual Mid-Winter meeting

"Brachytherapy: The First Hundred Years"

December 10-13, 1995

Hyatt Regency Scottsdale at Gainey Ranch, Scottsdale, AZ.

Contact: (215) 574-3158

Prosper Meniere Society

Annual Winter Meeting and the 5th Symposium on Inner Ear Medicine and Surgery

March 1996, Aspen, CO.

Contact: Jane Wells or I. Kaufman Arenberg, MD.(303)778-4235

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David C. Martz, MD
President, 1994-1995

Noah and the Federation of Medicine

"Noah. . . Noah, I want you to build an ARK. . ."

"Right!! .What's an ARK?"

Those of us who have heard Bill Cosby's legendary monologue of Noah and the Ark could probably quote much of it from memory, so powerful was his humorous portrayal of Noah's profound confusion over the incredible changes about to occur in his world.

Begging forgiveness for the exaggeration of the analogy, we too are struggling to comprehend the flood of changes sweeping us under in 1995, and it would be just great if "Someone" could tell us how to build an "Ark". Clearly the clouds are gathering and the rain is starting to fall all around us, while we scramble from one shelter to another with little hope of permanent safety in any of the nooks and crannies we have found so far.

Noah's plan was to get ALL the world's animals on a 300 cubit boat and ride out the storm together, and therein lies the comparison to our crisis.

Recognizing that better "to-gether" is the hope of survival, both the AMA and CMS are pursuing dramatic new undertakings with the intent to restructure the House of Medicine so it more accurately reflects the physician population we serve. This will be no easy task. . .but it is essential to our longevity.

The Federation Consortium (chaired by Dr. Joseph Painter, past president of the AMA) is a group of over 200 members of organized medicine that has been meeting for almost a year. Participants have been

selected to represent the various elements of our profession including the counties, the states, the AMA, and the specialty societies.

There are medical students, resident physicians, community clinicians, academicians, solo practitioners, group practitioners, managed care physicians, military and public health medics; the mix includes young and old, male and female, rural and metropolitan doctors from all corners of the USA. Staff personnel from all levels also participate.

This large group has met 3 times in the past 10 months in Chicago for 2 day deliberations, facilitated by the leadership of Glenn Tecker and Associates who provide the format and methodology for our input. This includes the hi-tech IRIS electronics which instantly collects and analyzes our responses to the hundreds of questions necessary to clarify the issues. Not only does it display the distribution of opinions, but also which subgroups differ in their vision of any given topic.

A core group of 28 members, called the Project Team, has met on several occasions in addition to the large Consortium that I attend. It has been their task to manage the overall effort. This includes the initial formulation to give us a place to start and a sense of direction, followed by analysis of the input received from the Consortium meetings (plus a number of supplemental Focus discussions with other medical leaders), and leading to a series of potential alternatives for us to consider at the next Consortium

(Continued)

"Noah. . . Noah, I want you to build an ARK. . ."

"Right!...What's an ARK?"

PRESIDENT'S LETTER

(Continued from preceding page)

meeting. By the third meeting held in late March some concrete concepts were emerging, and it is to these that I speak.

A six page summary of the Third Meeting of the Consortium is available for your detailed review if you desire (contact Mary Lee Johnston at 303/930-0422 to request a copy). Key elements gleaned from that publication include:

1. The current Federation is not well positioned to provide the type of services that physicians will need in the future. Physicians and medical associations will be better off if organized medicine designs a new Federation of Medicine by conscious choice rather than letting events take their own course.
2. Physicians would like the various elements of organized medicine to function more like a single organization that is able to speak and act in a unified manner.
3. The existence of a national medical association is in the best interest of the profession of medicine.
 - Although physicians support the ideal of a national medical association to which all physicians would belong, they also strongly believe that individual physicians should have a **choice** in which medical associations they join.
 - Incentives for unified membership should be strengthened.
4. Consortium participants are supportive of experimentation with changes in the structure of organized medicine (e.g., mergers, partnerships, chapter arrangements, etc.).
5. A common format or protocol for policy development is seen as a way to increase efficiency and help organized medicine speak with a unified voice.
6. Consortium participants believe that joint ventures have significant potential to strengthen economic linkages among medical associations and to

provide physicians with better products and services.

7. The AMA will have to play a strong leadership role, in partnership with all interested medical associations, in initiating and sustaining the process of creating a new Federation of Medicine.
The composition of the AMA House of Delegates and Board of Trustees will need to change to achieve a more balanced representation of the dimensions of physician practice.

The Consortium supports the concept that the representational systems used by organized medicine should relate to physicians along five dimensions: 1) geographic location; 2) specialty; 3) type of practice arrangement; 4) career state; and 5) demographic or other special groupings. Consistent with this approach, the Consortium supports an expansion in the number and variety of AMA Sections. In addition, the Consortium supported the concept that specialty societies should have proportional representation in the AMA House of Delegates and in the governance systems of other elements of organized medicine.

The exact mechanisms by which these modifications will be initiated remain to be elucidated by the Project Team and the Consortium over the course of the next year. Once their recommendations are crystallized, it will be up to the AMA House of Delegates to adopt, modify, or reject the proposals. And therein lies the rub: ***What is the likelihood that the AMA HOD will agree to dramatically reconstitute itself?*** That will depend on how convincing the presentation of the Consortium is, how effectively AMA leadership orchestrates the concepts, and how effectively the entire membership expresses its "Will".

And perhaps, at the heart of it all is a lesson from Noah: when faced with the deluge, he brought a pair of ALL the animals on board--not just his pets and domesticated beasts, but every species was included. And so it must be with us in the Federation of Medicine, both nationally and locally: if we do not respond to the

changing needs and populations of physicians in the '90s, we will have no life in the 21st century.

If we are to accomplish that, we must heed the words of Glenn Tecker as he coached us at the Third Consortium meeting:

"To establish a consensus, it is less important to discern the will of the majority than to be certain you have responded to the issues of the minorities".

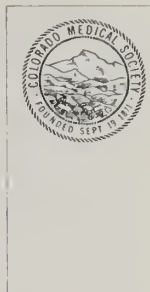
Watch for further developments in the work of the Consortium. Contact me personally if you have questions or recommendations. And recognize that we are already initiating many of these ideas right here in Colorado as we address the issues of expanding our outreach to partially-met elements (e.g., academicians, employed physicians, women physicians, etc.) and strive to "speak with one voice" through our coalitions among primary care physicians and specialty organizations.

And remember the need for innovative problem solving epitomized by those historic words:

"Noah. . . Noah, I want you to build an ARK."

"Right!. What's an ARK?"

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society

The AMA has held a series of meetings to discuss ways in which the AMA could collaborate with medical societies in the development of managed care products. I personally have spoken with several state medical society executives to determine what their states are doing to assist physicians in the area of managed care.

There is concern that national, state and county medical societies run the risk of losing members if we do not provide products and services that help physicians through this crisis. Services traditionally offered may not be sufficient to retain our membership numbers. In talking with members of CMS, they fully expect us to help them survive in medical practice. Some Colorado physicians do not expect anything from CMS because they look elsewhere for services that help them.

CMS provides advocacy for our members in the legislature regarding managed care issues. CMS should do more in the area of education and information. Several state societies are developing additional products designed to help their members respond to managed care. The general strategies being pursued by states societies, including CMS, can be divided into two categories:

- providing education and support services as physicians consolidate into groups.
- becoming a "player" in the market for physician health care delivery services or from managed care plans or both.

With input from state medical societies, the AMA's Private Sector Advocacy and Support Team developed the following categories for use

when discussing physician needs in a managed care environment:

1. **Information:** Physicians must learn the basics of managed care. What is managed care? Where is it headed? How does it work? What are the options, risk and opportunities?
2. **Advice:** After learning about managed care, physicians need counseling about how to respond to specific issues and trends, and they need guidance about what to do when faced with critical choices.
2. **Materials:** After deciding upon a course of action to respond to the managed care environment, physicians need specific materials and tools, e.g., guidebooks, model contracts, etc.
4. **Access to and Power in the Market:** Physicians need a way to be "a player" in the most advantageous way possible. This may mean developing or having access to health care delivery networks outside of their individual practices.
5. **Advocacy:** Physicians need someone to advocate on their behalf with government, managed care systems, and others to obtain regulations or procedures that enable them to respond to the environment better or which protects them against abuse.

Following are some products and services CMS may consider offering when responding to physician needs in the area of managed care:

(Continued)

Colorado Medical Society?

"... its primary role is to provide education and information to physicians about their options under managed care. . ."

EXECUTIVE DIRECTOR'S UPDATE

(Continued from preceding page)

1. Provide support services and advocacy
 - a. information
 - b. contract evaluation/advice
 - c. administrative support for POs (including developing an MSO)
 - d. assess/endorse managed care plans
 - e. assistance in organizing integrated networks (POs, PHOs)
 - f. advocacy in the form of:
 - seeking legislative, regulatory, or legal relief
 - negotiating with private sector players
 - serving as the watchdog for medicine
2. Be a market player with one or more of the following goals:
 - a. To become a dominant player
 - b. Market factor/"presence"
 - provide an opportunity for the other disenfranchised
 - provide a "preferred plan"
 - keep other players honest

Services being provided by other state medical societies can be identified as follows:

- **Education and Information** - Publications, workshops, etc.
- **Consulting**-Helping individual physicians or groups with problems
- **MSO** - Providing administrative support services
- **MSO Plus** - Provision of administrative support services plus marketing physician organizations as if they were one network or health plan
- **Network** - Developing a network or managed care plan

Going back to the two strategic categories I mentioned earlier, CMS is focusing on the area of education, information and advocacy. The Colorado Physician Network, Inc. is undertaking the second strategic category, which is to become a "player" in the health care delivery market. CMS has proceeded with the belief that its primary role is to provide education and information to physicians about their options under managed care, and to advocate on their behalf with legislators, regulatory agencies, and payers. Do you agree with this approach?

It is probably not appropriate for CMS to continue with its traditional education and information role. The uncertain future of medical practice makes it difficult to predict exactly what education and information physicians need. CMS, therefore, must undertake greater efforts to reach out and stay in touch with the members. We must learn exactly what information physicians want and provide that information on a timely basis. Should CMS try to promote a particular solution? Should physicians find their own solutions with the help of CMS?

Identifying and fulfilling the needs of CMS members will be challenging. However, we have already begun in many areas. Following are some of the services we provide.

Advocating on behalf of CMS members on legislative and regulatory issues is done without question. With the help of Doctor John Farrington, CMS is preparing volume two of the *Physician's Guide to Contract Analysis*. This publication should be available by fall of 1995. By the time you read this, CMS will

have hired a part-time physician consultant. This person will act as a liaison between member physicians and managed care organizations. Please watch future issues of *Colorado Medicine* for details on this advocacy program. As reported in previous articles, CMS has signed an unprecedented agreement with the Colorado HMO Association. This "White Paper" details affiliation and disaffiliation issues. Disaffiliation matters will also be part of the physician consultant's responsibilities. Through the President-elect's Planning Conference as well as meetings of the House of Delegates, CMS provides educational opportunities for the membership on various managed care topics. One matter under consideration is whether CMS should review managed care contracts for individual members.

I am certain there are other services you feel CMS should be providing. Please let us know what those services are.

We want to meet the needs of the "grassroots" membership, but can't do so without your input. Let me hear from you!

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Council on Legislation Chairman, Dr. Richard Allen, is touring China and the following legislative update is presented by Lorraine Koehn, Director, CMS Department of Government Relations.

Legend: *SB* = Senate Bill; *HB* = House Bill; *HEWI* = Health, Environment, Welfare & Institutions

In less than one month the legislature will adjourn *sine die* and your lobbyists are down to following less than 10 bills compared to the 60 plus proposals we've been watching throughout this session.

SB 40 Continuation of the Health Data Commission, has passed the Senate HEWI and Appropriations Committees and is awaiting Senate floor action. CMS amendments are included in the bill as it is now written and we will be closely monitoring the bill as it makes its way through the legislative process.

SB 76 Concerning a Statewide Trauma System, has passed the Senate and House HEWI Committee and is awaiting action in House Appropriations Committee.

SB 162 Qualifications of the Executive Director of the Health Department, was amended and passed by the Senate HEWI Committee. CMS will be working hard to defeat this bill which now says that the Executive Director of the Health Department must be a physician OR a person trained in public administration, public health and environment who should recruit a person with the department to serve as Chief Deputy and Medical Director. We're depending on our membership to help us explain to legislators the reasons why the Executive Director should be a physician.

SB 164 which mandates seat restraints in motor vehicles for all children under the age of 16 has passed and is awaiting the governor's signature.

SB 212 Elimination of the Restrictions on Employment of Physicians by Hospitals, passed the

Senate HEWI Committee on a 6/0 vote - 1 person was excused. CMS worked with the Hospital Association to assure that the protections for physicians included in our policy on corporate practice are reflected in the bill. CMS has taken a neutral position on SB 212.

HB 1002 the Medical Practice Act (MPA), is still awaiting action in conference committee. Rumor has it that this bill will carry that status until HB 1007, the Nurse Practice Act, (NPA) is passed - should the NPA be killed, there is a possibility that the MPA is also doomed. What does this mean? Each board would be given a year to wind down its activity and then nurses and physicians would be unregulated in the state. There would be no standards set for either profession so disciplinary actions would be nonexistent - it's quite possible that reimbursement by Medicaid, Medicare and many insurance companies would be jeopardized. New legislation would be required to create a governing body for these professions. Granted - it is a remote possibility but precedent was set when a bill renewing the Board of Physical Therapy was killed several years ago - physical therapists now operate without a licensing board and remain under the jurisdiction of the Executive Director of the Department of Regulatory Agencies.

HB 1007 the Nurse Practice Act, should be heard in Senate Appropriations Committee within the next few days and then will be sent to the floor of the Senate for action

"The CMS-sponsored HB 1262, which required employers to offer a "Point of Service" option for their employees, was killed in House Appropriations Committee (6 to 5) on March 30."

(Continued)

THE LOBBY

(Continued)

The CMS-sponsored **HB 1262**, which required employers to offer a "Point of Service" option for their employees, was killed in House Appropriations Committee (6/5) on March 30. Votes in favor of HB 1262 were: Representatives Ben Clarke, Denver, Bill Martin, Colorado Springs, Phil Pankey, Littleton, Gil Romero, Pueblo, and Todd Saliman, Boulder. Please take time to thank these legislators - your thank-you notes can be addressed to the State Capitol Building, 200 East Colfax, Denver, CO 80203. Those who voted against HB 1262 were: Representatives Vicki Agler, Jeanne Adkins, Bill Jerke, Tony Grampsas, David Owen, and Carol Snyder. The business community convinced these legislators the bill would have a fiscal impact on small business.

The amended version of **HB 1255** placed a liability limit of \$150,000 on medical liability claims

against physicians providing charity care. COPIC worked with the Senate sponsor to assure that retired physicians would be covered through tail coverage if they chose to provide charity care. The bill was killed on the Senate floor but we expect it will surface again next year with improved provisions for those who wish to serve their communities in this fashion.

HB 1329 Parental Notification, would require notice to parents of teenage children who seek medical care for termination of pregnancy. The CMS Council on Legislation voted to oppose this bill after reviewing RES-62-P ('92) concerning Confidential Health Services for Adolescents. The bill passed the House State Affairs Committee and is awaiting action in House Appropriations.

Thanks to each of you (1,400 plus) who took the time to respond to our questionnaire concerning the Medicaid Automated Payment (AMP) system.

CMS continues to tabulate the responses and has scheduled a meeting for April 17, 1995 with Richard Allen, Acting Manager of Health and Medical Services at the Department of Health Care Policy and Financing (Medicaid) and members of his staff to discuss this issue on behalf of our members. CMS has also requested to present the information received from the survey to the Board of Medical Services at its April 21, 1995 meeting. This request has not yet been granted. CMS will continue to keep you current with our efforts to carry out your wishes regarding the Medicaid AMP system. Please watch future editions of *Colorado Medicine* for our progress.

Call the CMS Department of Government Relations for updates on all 1995 health-related legislative proposals at 1-800-654-5653 or 779-5455, Ext. 410 or 427.

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000

Time for Form and Agreement Review?

Question: Are the agreements and forms which you utilize with your patients, subscribers, third-party providers, and governmental entities current, legally sufficient, and protective of your rights and duties? By way of example, Colorado law provides that a health care provider and patient may agree to arbitrate disputes. However, no medical malpractice insurer may require a health care provider to utilize arbitration agreements as a condition of providing medical malpractice insurance to such health care provider. Any such arbitration agreement must contain the language:

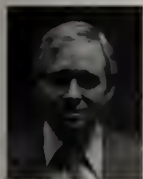
It is understood that any form of medical malpractice, including any claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered or omitted, will be determined by submission to binding arbitration in accordance with the provisions of the "Uniform Arbitration Act of 1975", part 2 of article 22 of title 13, Colorado Revised Statutes, and not by a lawsuit or resort to court process except as Colorado law provides for judicial review of arbitration proceedings. The patient has the right to seek legal counsel concerning this agreement, and has the right to rescind this agreement by written notice to the physician within ninety days after the agreement has been signed

and executed by both parties unless said agreement was signed in contemplation of the patient being hospitalized, in which case the agreement may be rescinded by written notice to the physician within ninety days after release or discharge from the hospital or other health care institution. Both parties to this agreement, by entering into it, have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

Colorado law also mandates that a four-paragraph notice, in bold-face type, be set forth immediately preceding the signature lines for such agreements. These paragraphs advise the patient that there will not be a jury or court trial but, rather, an arbitrator, inform a patient of the right to legal counsel, and advise the patient that medical services cannot be denied because the patient has refused to sign the agreement or exercise the rescission right.

For further information please contact:
A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

COLORADO PHYSICIAN NETWORK UPDATE



Thomas J. Allen, MD
Vice President
Colorado Physician Network

Colorado Physician Network, Inc. (CPN) has been established for the sole purpose of studying the feasibility of developing a physician organization or network throughout Colorado. The CPN Board of Directors has contracted with David A. Ginsberg Consulting of Santa Fe, New Mexico to conduct the study. The Board, along with Mr. Ginsberg, has identified the following core values for any organization that will potentially be developed as a result of the study.

Colorado Physician Network Core Values:

1. Quality patient care is the primary goal. CPN seeks to maintain the primacy of the physician/patient relationship and optimize their respective roles in clinical decisions. Increasing patient access to high quality physicians is a major focal point.
2. Advocacy for physician rights and issues is also of prime importance. CPN promotes a stronger physician role in managed care and increased physician control over the practice of medicine in order to ensure the patients receive high quality and appropriate medical services. CPN seeks to present accurate information on physician issues and points of view.
3. CPN supports a structure that enhances physician access to patient populations as well as maintains present patient access.
4. CPN seeks to improve the current delivery of health care and administrative efficiency.
5. CPN advocates the use of incentives, positive reinforcement and related approaches as effective ways for influencing physician behavior.
6. Physicians need to be in control of the development, analysis and distribution of data that is used to evaluate and profile physician performance.
7. CPN is an innovative, proactive organization that responds in a deliberate and well thought out manner to change.
8. Membership in CPN is based on fair criteria.
9. CPN is a fiscally responsible organization committed to the long-term financial success of all of its members.
10. CPN is dedicated to the long-term viability of physician practices.
11. CPN is committed to developing and implementing the next generation of managed care systems that demonstrate strategic partnerships with payors, hospitals and other parties for the good of patients.

The Board believes these values are the foundation upon which any organization that is ultimately developed must be built. The values identified above are considered a starting point and may be modified or refined as discussions continue.

One approach to developing a physician organization identified by the Board would be to work with a joint venture partner. Mr. Ginsberg is in the process of conducting interviews with potential partners. His final report is expected by the end of May.

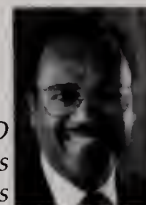
Colorado Physician Network Core Values

Note: Colorado Physician Network, Inc., (CPN) is a private, not-for-profit corporation that is wholly independent of any other organization or business. It is operated by a volunteer physician Board of Directors.



Glimpse of the Future?

James Mann, MD
Vice President, Quality Resources
Provenant St. Anthony Hospitals



Reprinted from the Provenant St. Anthony Hospitals Central and North Medical Staff Newsletter (March, 1995)

Friendly Hills Health Care Network: A Glimpse of the Future?

On Oct. 13, 1994, a group of physicians and administrators from Provenant Health Partners paid a visit to the Friendly Hills Health Care Network to view first hand how an integrated health care delivery network actually operates. I believe what we saw and heard will be of interest to you, as increasingly market forces are requiring the development of integrated health care delivery networks here in Colorado, particularly in the metropolitan area.

The Friendly Hills Hospital Network (FHHN) is located in North Orange - East Los Angeles counties and had its beginning approximately 25 years ago. It currently contracts with more than 25 health plans to provide medical services to over 100,000 insured patient lives. It is fully capitated for both inpatient and outpatient services, and 95 percent of its revenue is derived from prepaid managed care contracts. All services are provided company-wide and all management has both inpatient and outpatient responsibilities. FHHN is owned by the Friendly Hills Foundation, a nonprofit entity which in turn capitates the Friendly Hills Multi-specialty Medical Group. The Friendly Hills organization was founded in 1968 by three physicians and has since grown to its present size of nearly 200 physicians and allied health professionals with expertise in more than 30 medical specialties. These physicians and health care professionals utilize 13 office sites in North Orange and East Los Angeles counties.

The Friendly Hills Regional Medical Center is a full-service hospital containing 274 acute care beds. It utilizes various patient care delivery models designed specifically to enhance managed care concepts. The hospital is fully owned by the foundation and is one of the "only managed care" hospitals in California. It is considered just an access point along the continuum of care concept. FHHN has a staff of 1,800 employees and its service area includes 14 cities with a combined population base of more than one million people.

I believe the secret of success at FHHN rests in the fact that everyone in the organization is aligned and motivated to carry out the goals contained in its mission statement: 1) To design and promote high quality, value-enhanced and innovative health care delivery systems; 2) To assist through its own efforts and those of community agencies in promoting wellness through awareness and practice of health maintenance techniques and preventive care; 3) To integrate the delivery of all components of health care and to enhance the quality and value of health care delivered to the community; 4) To provide an extensive and useful array of educational opportunities to both patients and professional staff.

The Friendly Hills Health Care System is based upon the primary care physician and staff providing the most basic services supported by highly skilled specialists within its own organization. Its physicians have no incentive to order costly, duplicative tests or to perform unnecessary procedures. Conversely, there is every incentive to improve quality and to use resources wisely, thereby increasing value to the patient.

The emphasis in this system is on wellness. Everywhere one looked there was evidence of this, from the very well organized telephone advice system to the Coumadin Clinic, to the Wound Management Clinic.

In the Telephone Advice System (TAS) any covered patient who accesses the system speaks directly with a nurse who uses telephone management skills to evaluate the patient's complaints and to prioritize. A suitable disposition of the patient's

health-related problem is then done by telephone with the use of approved protocols. This has led to a more appropriate utilization of services and staff and the development of standards and protocols by a multidisciplinary task force. The TAS has also improved the quality of care as measured by providing consistent and accurate information, patient education and instructions for self-care and increased patient satisfaction.

Any patient who is placed on Coumadin anywhere within FHHN is referred to the Coumadin Clinic for follow-up. Here a clinical pharmacist, under the direction of, and with criteria established by the physician, manages the patient's anti-coagulation. He/she evaluates all medica-

tions taken by the patient and determines the frequency of prothrombin times. If the patient fails to keep an appointment for a prothrombin time when scheduled, someone goes to the patient's residence and obtains the blood specimen. With this very aggressive management, complications surrounding anticoagulant therapy have dropped dramatically. The need for hospitalization from these complications also has decreased.

The average daily census in the 274-bed hospital is approximately 80. This low rate is achieved by the emphasis on wellness, patient education, active case management and other activities, some of which I have mentioned.

Clearly the situation at Friendly Hills is totally different from that which exists here in Denver. There are, however, lessons to be learned. Hopefully, we will seize the opportunities offered in some of these areas.

Editor's Note:

Some of the future even Dr. Mann's group could not glimpse was the fact that Friendly Hills Health Care Network and all its appurtenances was about to enter into a contract with **Caremark International** of Northbrook, Illinois. *Caremark* now manages the entire operation, something probably not anticipated just eight months ago.

Leading Physician Management Companies

from: *American Medical News*

PhyCor, Nashville, Tenn.

- Estimated 1994 revenues: \$233 million
- 3-year average growth: 30%
- 22 clinics. 1,200 physicians in 12 states
- Medium to large multispecialty groups
- Focus on smaller markets with less managed care
- Primarily in group practice business

Caremark International, Northbrook, Ill.*

- 1993 revenues: \$1.8 billion
- 3-year average growth: 24%
- Four clinics (fifth pending). 600 physicians in 5 states
- Large multispecialty groups
- Focus on capitated contracts
- Group practices are small part of broad outpatient business

Coastal Healthcare Group, Durham, N.C.

- Estimated 1994 revenues: \$695 million
- 3-year average growth: 25%
- About 400 primary care doctors, 140 clinics in 7 states
- Owns HMOs
- Group practices part of broad physician services business

Pacific Physician Services, Redlands, Calif.

- Estimated 1994 revenues: \$213 million
- 3-year average growth: 25%
- 325 doctors, 54 sites in 4 states
- 75% primary care
- Focus on capitated contracts

**Caremark*, the newest of the four in this field, has recently contracted with Friendly Hills Foundation to manage both the network and the network-owned hospital. *Caremark* has acquired large multispecialty practices with significant capitated experience in heavy managed care markets (though one of its latest acquisitions, Atlanta Medical Associates, is light on prepaid experience). It just announced the sale of its financially and legally troubled home drug-infusion business so it could concentrate on practice management.

Others: MedCath, InPhyNet, Health Spring, Summit, Heritage, American Health Care Groups, Physician Reliance Network, FPA, First Physician Care, Equivision

Source: Jason Rosenbluth, MD, Volpe Welty & Co., San Francisco; company annual reports



Physicians Capital Source

American Medical Association — Project Overview

by Bill Pierson, Director
Member Services

with information from the American Medical Association

The American Medical Association's (AMA's) Physicians Capital Source is built on the premise that physicians are best suited to lead the health care delivery systems that are developing across the country.

Physician leadership in these systems is essential to maintain the high quality of care that is unique to the U.S. and to allow physicians to uphold their ethical obligation to put patients first.

The Project's goal is to facilitate formation of physician-led ventures by providing education and hands-on assistance to physicians who are seeking to create such ventures. Specifically, the Project will assist physicians with the two most critical steps in the creation of a business: development of a solid business plan and identification of and access to potential financing sources.

Business Plan Development and Review

Several documents have been created to provide physicians with a "blueprint" for business plan development. First is an extensive "Request for Information" (RFI) that identifies the major components of a viable business plan. The RFI was developed specifically for physicians by a team of expert financiers, business consultants and the AMA. As physicians answer the questions posed in the RFI, they will confront the strategic and operational issues involved in creating a new venture — the issues that financing sources consider vital to evaluating a proposed venture.

The RFI is explained on a section-by-section basis in a concise guide to business plan development. The guide, along with model business plans, is designed to help physicians craft a solid and comprehensive plan. These documents will enable physicians to gain a significant "head start" that should materially reduced the

amount of fees typically required to retain a consultant for business plan development.

Once a business plan is complete, the physician submits it to the AMA for evaluation by the Project Steering Committee. The Steering Committee is composed of AMA representatives, financiers and business consultants. Based on a summary review of the plan, the Committee's financing and business members determine whether the plan should proceed to financing or whether it needs more development.

If a business plan needs further development, the physician will be contacted and specific areas of plan weakness will be identified. The physician will be referred to a member of the Physicians Capital Source Advisory Committee — a national panel of managed care experts, legal advisors, business consultants and financiers who support the Project's goals. The Steering Committee will select an Advisory Committee member who has expertise in the particular type of proposed venture (e.g., development of IPAs, integrated delivery systems, physician networks, group practices, etc.). The physician may retain the recommended consultant, or any other, to bolster the plan and may then submit the revised plan for Steering Committee review.

Referral for Financing

When the Steering Committee determines that a business plan is ready for funding, it will refer the plan to a financing member of the Physicians Capital Source Advisory Committee. Physicians will only be

(Continued)

Physicians Capital Source

(Continued from preceding page)

referred to the types of financiers who are most likely to meet the objectives defined in their business plan, whether venture capital firms, investment banks, commercial banks or others. If that member is unable or unwilling to finance the deal, the Steering Committee will pursue other financing sources.

Physicians will be consulted about the type of financing they prefer; a concise explanation of basic financing terms and concepts has been developed to assist physicians to understand financing fundamentals and is included in the guide to business plan development.

Criteria for Participation

The Project is open to all physicians who have developed "physician-friendly plans" as defined in the group's Statement of Operating Principles and Guidelines.

Physicians who are not AMA members pay an application fee; the application fee is waived for AMA members. The application fee covers administration of the Project and the initial reviews and evaluations performed by the Steering Committee and Advisory Committee members. Subsequent consultations with members of either Committee will be billed at rates negotiated between the physician and the committee member.

Advisory Committee members pay modest fees to the AMA upon successful financings, or when retained for business plan development, to offset the Project's direct expense.

A substantial practice development effort and pursuit of funding may require a significant investment. Capital acquisition, depending on the source, often involves fees, pledged assets and/or equity participation, which should be factored into financial planning.

Support for Physician Transition to Managed Care

Neither the AMA, acting through the Physicians Capital Source, nor the Steering Committee can guarantee that a particular physician-led venture will be funded or will ultimately succeed. While there are never guarantees in any line of business, Physicians Capital Source will provide a support system for physicians making a transition to a managed care environment. The process is designed to be efficient and to minimize false starts, exorbitant investment in impractical business plans and inappropriate approaches to capital sources.

For More Information

For more information on Physicians Capital Source call the AMA's Managed Care Help Line at 800 AMA-1066, press 2.



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Tomorrow's Health Care System

by Cheryl Adams
Mesa, Colorado

This Month's Winner in the CMS Essay Contest

Introduction: In response to a resolution from Arapahoe Medical Society at the Annual Meeting in September, the Colorado Medical Society established an essay contest on health care reform. After plans were finalized by the Executive Committee on January 4, 1995, news releases and other information went out to various media outlets in Colorado. The idea behind the contest was to get input from the end users of health care (your patients) concerning how the system should work. The response indicates that patients are grateful their physicians desire their opinions and input.

Here we publish the third of three monthly winners. Ms. Adams and two others will receive checks for \$100 for their entries. There will also be a grand prize of \$500 and a second prize of \$200, to be awarded in June.

Is a federal health care or insurance system necessary? If so, what components would be needed?

We must have some form of national health care or insurance system. With over 15% of our population uninsured, those of us with insurance pay for the care of these people already. We pay for their costs in raised prices or other forms of cost shifting, and we pay for them to use the most expensive form of medical care.

A national health care or insurance system must be heavy in education and prevention. My reasons for this can easily be seen in a few figures on preventable diseases. Coronary artery disease affects 7 million people each year. 300,000 coronary bypasses are performed on Americans yearly, at a cost of \$30,000 each. Many of these could be avoided with changes in diet and exercise. Drug abuse affects the lives of 375,000 natally exposed infants each year. The 5-year cost associated with this exposure is \$63,000 per child. The cost of lung cancer is estimated at \$29,000 per patient. These too, can be corrected with a change in lifestyle; prevention prompted by education.

Early intervention is another aspect which must be included in any new health care system. When disease is allowed to go without care, many people end up in emergency rooms, where current law says they cannot be turned away. It is common knowledge that emergency care is the most expensive form of care available. For instance, if caught early, breast cancer is one of

the most treatable forms of cancer. Mammograms can aid in early detection (as can self-examination if taught), when lumpectomies, a dose of chemotherapy, or mild radiation can bring a cure.

However, once the tumor has metastasized, the patient looks at much more costly and invasive procedures such as mastectomy, larger doses of chemotherapy or radiation, and often lifetime medications or even Stemcell Replacement Therapy.

People also need a form of insurance or health care that they can keep as they move from job to job. Our society is very mobile today. Few people retire from the same job that they start out in. Let's say a man finds that he has an illness which he believes to have been exacerbated by the high stress level involved in his job. He moves to a new job, which has a new insurance company. For several years his illness gets better. But after 5 years it returns again. His new insurance company probably will not cover the illness because they will say it is a preexisting condition.

Our country has debated many forms of insurance and health care systems since the 1960s. But these three things have not been talked about enough and must be included in any new form of health care, regardless of who pays for it. Any new system must include strong education and prevention programs, must lean heavily on early intervention, and must be available to all members of society, no matter where they work or live.



Preventing Prescription Drug Diversion and Abuse

Call-Back Scam

A rather complex scheme involving illicit Valium prescriptions has been reported recently by narcotics agents. Valium is abused by many addicted individuals, often taken in conjunction with alcohol or other sedatives, or to cope with heroin or cocaine withdrawal. A 10 mg. Valium sells for \$2-\$10 on the street.

The crook calls a pharmacy, identifying himself as a physician, and orders one hundred (100) 10 mg. Valium tablets for Patient "X". he then waits about an hour and, before taking the risk of picking up the prescription, he calls the physician whose name he used and pretends to be a pharmacist from a different pharmacy. He asks the physician if any pharmacies have called to check on Valium Prescriptions for Patient "X", as there has been some trouble with phony scripts. If the physician says "yes", the crook knows he has to start the scam over with another pharmacy and another physician's name.

Solution for Call-Back Scam

1. Does the physician even have a Patient "X"? If not, this should alert the physician immediately to a possible scam.
2. The telephone call from a pharmacist should alert the physician to the possibility of trouble. Whether the call is from a scam artist impersonating a pharmacist, or a legitimate pharmacist, the physician may wish to begin verification procedures of his own at this point.
3. Ask the caller for his name and the name of his pharmacy. Call the

pharmacy back to verify the caller's identity. At this point, if the caller is identified as an impostor, a pharmacy hotline (if operational) should be put to use. The police should also be notified at this time.

Car Phone Scam

The crook contacts a pharmacy, identifies himself as a doctor, and states that he is calling from his car phone. He calls in a prescription, stating that he is on his way out of town, and will soon be out of the range of the pharmacy. This is meant to hinder a callback by the pharmacist for verification.

The crook also tells the pharmacist that there is no point in calling his (the "doctors") office to verify this prescription, as they will have no record of it yet. He has only just received a call on his car phone from the patient for whom he is requesting the prescription, so his office will not be aware of it until the doctor returns from his out-of-town trip in a day or two. This is also meant to distract the pharmacist from attempting to verify the call right away. (Submitted by Detective J.D. Gray, Denver Police Department, March 1, 1990)

Solutions for Car Phone Scam

The pharmacist should go ahead and call the doctor's office anyway, to verify:

1. That the doctor is actually going out-of-town.
2. That the doctor has a patient of the name used for the prescription.
3. That the doctor does, indeed, have a car phone.
4. If so, did the call sound like it came from a car phone (traffic noise, "tunnellike" sound quality, etc.)?

According to Congress, the National Institute of Drug Abuse, and the Drug Enforcement Administration, prescription drug abuse is the cause of more injuries and deaths than all illegal drugs combined. In cooperation with the Colorado Prescription Drug Abuse Task Force, Colorado Medicine presents various Drug Diversion "scams" and offers possible solutions.

*If you or your staff are aware of a "scam" please contact:
Colorado Prescription Drug Abuse Task Force
1425 Market Street, Suite 225
Denver, Colorado 80202
(303) 534-4663*



An introduction to the new structure of delivery systems

by Mark E. Wallace, MD, MPH, Health Affairs Council
Colorado Medical Society

"Integrated Delivery Systems" (IDS)



Mark E. Wallace, MD

The decade of the 1990s has ushered in an era in health care reform that is seeing widespread reorganization of delivery systems. An unlegislated, marketplace mandate is at play driving a reduction in areas of excess capacity and demanding new efficiencies in the delivery of services. Innovative and cooperative organizations are being formed between parties that have not traditionally joined in collaborative efforts.

These newly developing delivery structures have been referred to by various names. The American Hospital Association has referred to "community care networks", the Jackson Hole Group and the Clinton proposal have used the label "accountable health partnerships" and the Internal Revenue Service identifies these new entities as "integrated delivery systems" (IDS)^{1,2}. Even new applications of an older model are being applied to physician-hospital organizations (PHO)³. Despite the differences in terminology, the fundamental characteristic of an IDS is the ability of the organization to provide and control the delivery of both physician and hospital services

to patients. An integrated payment mechanism, however, is not a necessary component of all these new systems.

The goals of all these organizations are the same as they strive to be successful in the evolving health care market. Each system must seek to find an infrastructure that moves away from a delivery mechanism that is characterized by fragmentation, fee-for-service, solo-practice, specialist centered and hospital capital intensive to one which is cooperative, capitated, networked, primary care focused and vertically integrated from the delivery of primary outpatient services through tertiary inpatient care.

California appears to be leading other markets with accumulated experiences in the managed care market and in the development of vertically integrated systems. Peter N. Grant, J.D., Ph.D., partner in the San Francisco law firm of Davis Wright Tremaine has identified basic characteristics shared by integrated delivery systems¹:

1. Focus on primary care - generalist physicians form the foundation of the provider pool and are empowered both in governance of the system and as case managers controlling and directing patient access to services;
2. Coordination of care - management systems are structured to guarantee and control the coordination of inpatient and outpatient health care services;
3. Single integrated system - infrastructure exists to provide vertically integrated service delivery from community-based primary

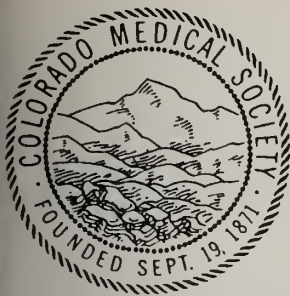
care through tertiary inpatient care in traditional medical center environments;

4. Shared economic risk - provider system of physicians and hospitals assumes the financial risk for providing full range of health care services to defined patient populations.

Physicians and hospitals must learn to be proactive, rather than reactive, in forming provider alliances in a joint effort to preserve some influence over their destiny as insurers look to control costs and direct managed care delivery systems. Providers and system managers are learning how to make a massive shift away from the traditional paradigm of increasing bed occupancy and utilizing capital intensive resources to a new paradigm of optimal utilization of outpatient, primary care services and aggressive case/risk management². If physicians choose not to play an active role in the formation of these new delivery systems, insurers and regulatory reformers stand poised to seize center stage in directing the next evolution in the healthcare marketplace.

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2. Cochrane JD. Integrated delivery systems reposition for reform. *Med. Group Manage J.* 1993 Jul-Aug;40(4): 14-6,18, 20 passim.
3. Peter GR. Organizational and business issues affecting integrated delivery systems. *Top Health Care Financ.* 1994 Spring;20(3):1-12.



COLORADO MEDICAL SOCIETY

"Advocating excellence in the profession of medicine."

Dear Colleague:

No longer is it acceptable to simply discuss issues and set policy. If we want CMS and our profession to survive in these turbulent times and the future ahead, we must set reasonable goals and then determine the best ways to achieve those goals.

This year we have started on a new paradigm for Colorado Medical Society. We have begun to tackle **the most important issue, taking back control of the health care delivery system for our patients and our members.** Those forces currently controlling medicine don't believe that we have either the joint resolve or ability to mount a challenge. Such an undertaking requires the knowledge and efforts of a great many physicians. I am committed to lead CMS physicians into previously untested waters. But to do so will require your help.

If you are tired of the direction medicine is taking, become part of the CMS team for next year. In order to assist me in building the right team, please examine the Council/Committee charges on the reverse of this letter, fill out the attached interest form for Council and Committee appointments and return it to me. If you are not sure where you might help, check off the appropriate line, and I will call you.

Please commit to your future and the future of our patients. Together we can make a difference!
Thanks!

Sincerely yours,

Joel M. Karlin, MD
President-elect



☐ Yes, Joel, I want to help. Please consider me to serve on the following Council or Committee:

☐ Joel, please call me so we can discuss my participation.

Name: _____

Telephone: (day) () _____ (evening) () _____

Address: _____

Here is my previous participation:

Component Society: _____

Colorado Medical Society: _____

Specialty Society: _____

CMS Council and Committee Charges

HEALTH AFFAIRS COUNCIL: Study the provision of medical care and the changing conditions and anticipated proposals affecting the practice of medicine. Such issues shall include, but not be limited to, matters concerning the provision of quality medical care, socioeconomic issues, public health issues, data collection, analysis and dissemination and third party payer issues. The Council shall recommend and promote policies of CMS when appropriate.

DATA COMMITTEE: The Data Committee reports to the Health Affairs Council. The Data Committee was initially charged with developing recommendations for CMS policy regarding physician-specific data. That completed, the Committee was asked to develop recommendations regarding appropriate data and quality issues in which CMS should be involved. These have been determined to be: (1) member education, (2) policy support, (3) MD office automation and (4) small area analysis. The Committee is working on the implementation of the above projects.

PROFESSIONAL EDUCATION AND ACCREDITATION COMMITTEE: The Committee on Professional Education and Accreditation shall promote the policies of the society in all matters concerning postgraduate medical education. The Committee shall: CME Function: 1) Maintain its accredited status by adhering to the Essentials and Standards as set by the Accreditation Council for CME (ACCME); 2) Have sole responsibility for issuing credits, and assisting with implementation of the CMS Annual Meeting CME program and all other CME events sponsored by CMS; 3) Sustain continuing liaison on postgraduate educational matters with organizations, local, state and national, that are concerned with continuing medical education; Accreditation Function: 4) Maintain its Certificate of Recognition to accredit organizations on an intrastate basis by adhering to the criterion set by the Committee for Review and Recognition (CRR); 5) Advise the Health Affairs Council (for ratification) on new or revised policies and procedures governing the Society's accreditation of continuing medical education programs; 6) Decide which applicants for accreditation shall be surveyed to determine their eligibility for accreditation; 7) Evaluate findings of survey teams, and determine whether or not applicants are accredited and if so, for what duration; and 8) Provide educational support services for physicians and continuing education programs.

RURAL HEALTH TASK FORCE: The Rural Health Task Force reports to the Health Affairs Council. It is charged with 1) encouraging the development of rural training track residency programs, 2) working with the medical school to create an educational environment more supportive of rural primary care, 3) working to improve the financial situation for rural physicians so as to encourage more physicians to choose rural practice and retain those currently in rural Colorado, and 4) assist physicians with the issue of professional isolation by working with the University, Rural Health Resource Center and other local agencies to integrate and expand existing locum tenens programs in order to provide relief to rural physicians at little or no cost.

YOUTH TASK FORCE: The Youth Task Force reports to the Health Affairs Council. The Task Force was convened to recommend and subsequently implement a project that would promote healthy lifestyles to children and youth. The Task Force is pursuing a project on comprehensive K-12 health education.

CREDENTIALING TASK FORCE: The Credentialing Task Force was created in response to member complaints on credentialing issues. Its focus is twofold. First, to respond to Resolution 56-A of the 1994 Annual Meeting of the House of Delegates stating that "CMS pursue the development of a statewide standard credential-

ing form to be used by all physician credentialing entities...and if a standard form cannot be agreed upon that at least a standard body of information be pursued that is agreeable by all parties." Secondly, to continue discussions regarding a centralized, credentialing verification service.

THE WORKERS' COMPENSATION/PERSONAL INJURY COMMITTEE: The committee shall study current and new state laws, regulations and policies regarding Workers' Compensation, Auto No-Fault, and other personal injury areas; Try to maintain fair physician reimbursement to ensure that there is an adequate number of qualified physicians to provide quality care to the citizens of Colorado; Promote open communication and participation with the Division of Labor and Employment, Division of Workers' Compensation, Division of Insurance, the State Insurance Commissioner, the Colorado Compensation Insurance Authority, private insurance carriers that offer casualty insurance, or any agent thereof; Provide testimony at any public hearing or meeting where changes are being recommended to any rule or regulation applicable to medical care within the Workers' Compensation, Auto No-Fault, or other personal injury arena; Educate the membership of all changes.

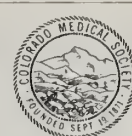
HEALTH SYSTEM REFORM TASK FORCE: The mission of the Colorado Medical Society Health System Reform Task Force is to examine national and local health system reform proposals and legislative issues, formulate positions regarding them and suggest alternatives where it feels that the presented plan is contrary to the interests of CMS members and to their patients. As the committee studies health system reform issues, it will also make recommendations regarding modifications to current CMS policy on health system reform.

COUNCIL ON LEGISLATION: The Council shall represent the Society in all matters pertaining to federal, state and local legislation and legislative bodies. It shall promote the determined policies of the Society with regard to: a) all proposed or pending health-related legislation, and b) the formulation of rules and regulations of governmental agencies for implementation of existing laws. The Council shall seek advice and assistance from other appropriate Councils or Committees in arriving at policy recommendations.

COALITION ON SENIOR ISSUES: The Coalition on Senior Issues, comprised of representatives from Colorado Medical Society and senior groups such as AARP, Gray Panthers, Colorado Commission on Aging, etc., serves as a forum to address issues relating to health care of seniors.

PATIENT ADVISORY COMMITTEE: The Patient Advisory Committee was established to 1) provide a mechanism for patients to inform CMS of their position on issues of importance to them as patients; 2) serve as a forum for open discussion of issues of mutual concern for patients and physicians; 3) allow patients and their physicians to work together to formulate and advocate joint positions on health-related matters; 4) influence public policy on jointly developed health-related issues; and 5) serve as a vehicle for outreach and education of the public.

CMS EDUCATION AND RESEARCH FOUNDATION (CMS ERF): The Colorado Medical Society Foundation for Education and Research (CMS ERF) is a nonprofit, tax exempt, charitable foundation established in 1982 primarily for the purposes of conducting scientific, educational and charitable programs. In addition to awarding scholarships to medical students, CMS ERF has provided financial support for the Colorado State Science Fair and the CMS Annual Meeting Education Program.



by Edie Register, Director
Jo Parkin, Program Manager
Division of Health Care Financing

Standard Formats Required for Medicare Electronic Claims Submission

If you are currently submitting electronic claims to Blue Cross and Blue Shield of Colorado (BCBSC) you will need to begin submitting your claims to the new Medicare carrier in Fargo, North Dakota as soon as possible and you will need to submit your claims in one of two standard formats.

HCFA has issued a mandate requiring that only electronic claims submitted in either the ANSI 837 or the Medicare National Standard Format be accepted by carriers. Consequently, Medicare Part B carriers will no longer utilize or support any local formats. This means that Colorado physicians using BCBSC local formats (i.e., 80-byte and 160-byte formats) will be required to convert to Medicare National Standard Format or ANSI standards for submission of Medicare Part B claims to Fargo.

The deadline to convert your Medicare Part B electronic claims submission from BCBSC to Fargo is December 31, 1995, but this is not the "target date" for conversion. The new Medicare carrier would like to have all current Electronic Data Interchange (EDI) submitters transmitting to Fargo within the next few months.

Physicians do not seem to be converting to the National Standard Format or ANSI format as quickly as was hoped. However, many providers and vendors are now beginning the transition process, and EDI Support Services reports that testing is picking up. Medicare Part B strongly encourages physicians to notify their vendors of the importance in establishing a schedule for testing and transmission. Physicians should be asking their vendors the primary question, "When will you be able to accomplish this task?"

As part of the conversion process, you will be required to submit at least one test file. This process is necessary to ensure compliance with National Standard Format or ANSI format

structure and Medicare Part B billing requirements. One danger in waiting until the last minute to complete the transmission to Fargo is that the carrier could be inundated with large numbers of physicians all wanting to do their testing at the same time right before the December 31 deadline. The carrier may not be able to accommodate these large numbers. As a result, some physicians currently submitting claims electronically may be required to submit paper claims until the carrier can catch up with the workload. The drawback to this is that paper claims are paid in 28 days, whereas electronic claims are paid in 15 days.

Following are the steps you should follow to ensure a smooth electronic data interchange (EDI) conversion:

- If you have not received the EDI Conversion Packet that was sent in January or the December 1994 EDI News Flash, call EDI Support Services to request copies at 1-800-279-2547.

- Confirm with your vendor which formats you are using for electronic claim submission to BCBSC: BCBSC 80-byte format, BCBSC 160-byte format, National Standard Format, or ANSI Format.
- If you are using BCBSC local formats for the submission of Medicare Part B claims, contact your programming staff or vendor. To continue electronic claim submission, you will need to convert to the National Standard Format or ANSI.
- If you are using National Standard Format or ANSI, you will need to make arrangements to create and submit your first test file.

EDI Support Services will work closely with you and your vendor as you make your electronic transition to your new Medicare Part B carrier. They also have an electronic billing software available to all Medicare Part B physicians free of charge. Call them at 1-800-279-2547 if you have any questions.



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RAM

Recent Affiliations and Mergers (in Colorado)

Prepared by Lorraine Heth, Program Manager
Dept. of Health Care Policy

Key: DP = *Denver Post*; CMC = *Colorado Managed Care Newsletter*; RMN = *Rocky Mountain News*; DBJ = *Denver Business Journal*; C/M = *Colorado Medicine*; NYT = *New York Times*

- **HSI Update:** Health Systems International, the parent of Pueblo-based Qual-Med, and WellPoint Health Networks, Inc. have agreed to combine in a stock swap. Leonard D. Schaeffer, chairman and chief executive of Wellpoint would be chief executive. Dr. Malik M. Hasan, chairman of Health Systems, would become chairman and major owner, with about 6 percent of the shares. Any deal is subject to approval by Gary S. Mendoza, the California commissioner of corporations. He said his department and its Wall Street advisor, Bear, Stearns & Company, were "reviewing the situation". (NYT 3/28/95)

It would be the first for-profit parent authorized to use the Blue Cross name and logo. The two companies together have 6,000 employees. Reductions are expected to be modest, reflecting the increased staffing needed to service a new \$2.5 billion military healthcare contract won by Health Systems in late March. (WSJ, 4/4/95) The company won a two-year battle to provide health care to 700,000 members of the military and their families in California and Hawaii. (RMN 4/4/95)

James Hertel, publisher of *Colorado Managed Care*, said, "I think Dr. Hasan would like a larger share of the Colorado market than he now enjoys. We may see increased focus on increasing enrollment in Colorado." (DP 4/4/95)

- A new hospital network is forming

in Colorado to contract with managed healthcare plans outside the metro Denver area. Ten hospitals managed by Quorum Health Resources, Inc. are involved. Quorum is a for-profit healthcare company based in Nashville, Tenn. with close ties to the former Hospital Corp. of America, now part of Columbia/HCA Healthcare Corp. Those participating are: Valley View Hospital, Glenwood Springs; Clagett Memorial Hospital, Rifle; Pioneers Hospital, Meeker; Memorial Hospital, Craig; Montezuma County Hospital, Cortez; Heart of the Rockies Regional Medical Center, Salida; Mount San Rafael Hospital, Trinidad; Powers Medical Center, Lamar; Montrose Memorial Hospital, Montrose; and Parkview Episcopal Medical Center, Pueblo. The group is currently trying to hire an executive director. (DP 4/5/95)

- Provenant Health System is actively reviewing the future of Denver's Mercy Medical Center, however a decision has not been made yet. According to spokesman Randy Shook, a task force studying Mercy would make a recommendation to the Provenant board within the next 30 to 60 days. The review coincides with a major management restructuring at Provenant. The restructuring consolidates management for Provenant's St. Anthony Hospitals Central and North, putting a single chief executive and team of managers in charge of clinical and administrative operations at the two hospitals.

Penrose-St. Francis Healthcare System of Colorado Springs also announced an extensive belt-tightening involving slashing \$40 million in operating expenses from its budget over the next two years eliminating 400 positions (half through attrition, half through layoffs).

Both reorganizations come a few weeks after their parent, the Sisters of Charity Health Care System Inc. of Cincinnati, announced plans to pull together all its Colorado medical institutions in a single statewide system, run by one set of corporate managers. (DP 4/5/95)

Colorado is the first state where the Sisters of Charity System has brought together all its facilities, creating a statewide not-for-profit healthcare system unprecedented in its size and scope. More than 50% of the Colorado population is now covered by managed healthcare, exerting extreme financial pressure on medical providers. (DP 3/26/95)

- Doctors at Rose Health Care System are organizing a new multispecialty physician group. If all goes as expected, as many as 150 of Rose's most active, influential physicians will join its new group by the end of the year, said Dr. Jeff Mishell, Rose's vice president of medical services. He said, "We're favorably disposed toward Columbia, but we need to maintain some independence" (referring to the Rose Board approval of the sale (Continued)

Recent Affiliations and Mergers

(Continued)

to Columbia/HCA). The organization plans to be operational this summer. Doctors would contribute assets and become shareholders in the group, which would be fully owned by physicians. The ownership structure distinguishes it from other groups being formed in the metro area, such as physician hospital organizations (PHOs), with significant financial assistance — and control — from hospitals. (DP 3/23/95)

- The Healthcare Initiative (THI), a 7-year-old managed care organization, agreed to a purchase proposal from Primera Healthcare, a fledgling firm seeking to establish a wide-ranging network of primary care doctors. Both have physician-hospital organizations affiliated with Lutheran Medical Center and Saint Joseph Hospital, among the metro area's leading low-cost hospitals. Through those affiliated

doctors groups, the hospitals have contributed financial backing to THI and Primera. THI, through its preferred provider and exclusive provider organizations (Coors) provides health care services to more than 50,000 members. (RMN 3/15/95)

Other News of Related Interest:

- In a controversial move that may nevertheless set a trend in the healthcare industry, General Electric Co.'s medical unit will assist in Columbia/HCA Healthcare Corp.'s future purchases of medical equipment and will take over maintenance service for diagnostic machines, including those made by GE's competitors. It is a five-year agreement. (WSJ 3/13/95)
- A study released by the Pharmaceutical Research and Manufacturers of America and Warner-Lambert Co. found that better managing or "integrating" patient care could save anywhere from \$30 billion to \$200 billion a year.

It urges pharmaceutical executives to focus more on business services that supplement the distribution of medicines they develop and market, and consider innovative contracts or alliances with managed care entities. (RMN 3/28/95)

• Quotes of Note:

Terry White, CEO Rocky Mountain Adventist Healthcare: "Future innovations will involve rationalizing how clinical services such as heart care are delivered across institutions, a step that Colorado hospital networks have not yet taken." (RMN 3/26/95)

Kate Paul, Kaiser Permanente: "The next step probably will bring health plans and hospital systems together in integrated systems. . . . But the really interesting decisions are yet to come." (DP 3/26/95)

Richard Scott, President/CEO, Columbia/HCA Healthcare Corp.: "I never give up." (DBJ 3/24-30/95).

Call for Nominations

The Nominating Committee, chaired by Barbara Reed, MD, will meet at the Leadership Conference May 6 and 7 to consider the slate for elections at the Annual Meeting of the House of Delegates in September. Currently, Dr. Terry Sullivan has declared his candidacy for President-Elect for the 1995-1996 term. Others who have notified the Committee of their interest in elective office include: Ted T. Lewis, MD, Speaker of the House; M. Ray Painter, MD and Mark A. Levine, MD, AMA Delegate; and Robert Bogin, MD and Joel M. Karlin, MD for AMA Alternative Delegate.

Nominations are also needed for Vice Speaker of the House, Council on Ethical and Judicial Affairs, Grievance Committee, and the Nominating Committee. Some members of the Board of Directors and other committees are eligible for reelection.

The Nominating Committee is charged with naming at least one qualified candidate for each opening. If you are interested in elective office, or would like to suggest someone to the Committee, contact Dr. Barbara Reed, 303-322-7789 or Mary Lee Johnston at the Colorado Medical Society.



RETIREMENT

Closing your practice: Start planning years ahead

By Joel H. Goldberg

It's a lot more involved than most doctors think. You have to consider your pension plan, patients, personnel, and insurance.

Twenty years ago, Chicago OBG specialist Albert Gerbie told his five partners he'd retire at the end of 1993. To their surprise, he did. Since he'd had so much time to prepare, his departure went smoothly for him and the group.

In contrast, a New Jersey pediatrician telephoned attorney Cal Feingold of Hackensack recently, seeking help in closing his practice. "I don't like the way things are going in medicine. I want out now!" he exclaimed. The lawyer urged him to give it at least one more year. "If you hire an associate and eventually sell him the practice, you'll be much better off financially," Feingold pointed out. "You'll have another year or two of income, and the sale price might be the equivalent of half a year's gross." But the pediatrician was adamant, although it meant losing the practice he'd built up.

Even so, he couldn't close from one day to the next. "Too often," Feingold explains, "a doctor doesn't know what's involved—for example, when and how to close out a retirement plan. And there are other matters to be taken care of, including your patients, office staff, patient charts and other records, and professional-liability coverage. That's why planning is essential."

A generous lead time is especially important if you're in solo practice or an expense-sharing arrangement and don't have partners to buy you out and take on your patients and other obligations (see page 152). Like the pediatrician, you could forfeit your practice by retiring abruptly.

In contrast, consider the retirement planning of Louisville orthopedist Ronald Fadel. This spring, the 55-year-old surgeon reached an oral agreement with a group of orthopedists. "They're located at another hospital's medical campus a 15-minute drive away, and they're eager to expand into my hospital's market," Fadel explains. "They'll buy my practice two years from now and hire a young doctor to take over."

For three or four years after that, Fadel will see patients in the office two days a week. That's to keep patients coming back while the new doctor builds his census. "I'll give up surgery altogether, which will reduce my malpractice exposure," Fadel declares, adding that his new work schedule, with its reduced paperwork, "will get me out of the sphere of Hillary-Billary."

Partners: Update your buy-sell agreement

An ophthalmologist who'd left his partner called *Medical Economics* recently to inquire: "What's the average buyout price for a doctor in my field? I think my partner cheated me." We referred the question to practice management consultants. Their reply: "You should have gotten whatever the two of you most recently agreed to - nothing more, nothing less." The ophthalmologist and his former partner had never changed their original agreement, and he thought his share of the practice was now worth far more.

Obviously, it's wise to update

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your buy-sell agreement at regular intervals. But suppose the practice equity hasn't grown in value as expected? "If all you're going to get is trailing receivable, perhaps you need to sit down with your colleagues and talk about giving you more," says Chicago attorney Jamie Stuart. "Even though they don't have to, they may be willing to make some adjustments," he notes. "After all, they'll be in the same boat when they retire."

One year ahead: Take care of the four "P's"

Whether or not you expect to sell your practice, certain matters demand attention well ahead of time. These are your pension plan, patients, personnel, and professional-liability coverage.

Don't forget that you have other people's money in your practice's retirement fund. At least a year before leaving practice, consult your financial adviser to make sure you'll be able to pay off all your employees who are vested in the plan.

"Some of them won't be old enough to take a distribution," notes attorney Feingold. "You'll have to start collecting the appropriate forms and notices so they'll be able to roll over their funds. You'll also want to be able to use all your own money the way you intended."

Collecting bills will be a big priority. In the last six months before quitting day, concentrate on reducing accounts receivable so that most of what you've billed for will be in

the bank. "Keep in mind that a patient who has been a reluctant payer in the past is going to be even more reluctant when you're no longer his doctor," attorney Stuart warns.

For that reason, don't be in a hurry to break the news to patients. Make it formal 60 days ahead of retirement, be sending a letter to every patient on your active list—usually defined as anybody you've seen in the past two years.

In the letter, explain when and why you're leaving practice, which colleagues you recommend, how patients can have copies of their charts transferred, and what your relationship with them meant to you (see page 156). However, don't pass up the opportunity to say good-bye in person as longtime patients come and go in your office, particularly those whom you see frequently for chronic problems and those who may need extra time to find new doctor. You can start these chats even before you send your letter.

With the letter, include an authorization form for the release of patients' medical records to another doctor of their choice. Keep a list of the patients you've notified, along with any envelopes that the post office returns to you.

It's also a good idea to follow up on pregnant and chronically ill patients, to make sure they've chosen other physicians and will continue to get proper care.

Even before the word goes out to patients, you'll have to tell your staff that you're leaving the practice. If you're solo and don't expect anyone

Some of the most common questions received by the Colorado Medical Society revolve around retiring, closing or selling a medical practice. Some of the best answers we have seen appeared in *Medical Economics* magazine in May, 1994. We have here reprinted that article.



RETIREMENT

Think early—and hard—about selling your practice

For doctors planning to leave an office-based practice, the first major decision will be whether to try selling it.

Despite the accelerating trend to group practice, the majority of practitioners — including 62 percent of internists, 58 percent of FPs, 60 percent of OBG specialists, and 48 percent of pediatricians — were in either solo practice or an expense-sharing arrangement in 1993, according to the *Medical Economics* Continuing Survey. Without partners to buy them out, these physicians have the following options:

Let your practice wind down. In this scenario, you ease up gradually, practicing part time and giving up high-risk services such as surgery or deliveries. Many retiring doctors limit their practices to the office setting and stop taking call.

The trouble with this is that expenses won't fall in proportion to revenue; the difference — your net income — will quickly dwindle. You'll still have to go through the practice-closing steps outlined in the accompanying article. And after you quit, you and your family will have nothing to show for your decades of hard work.

For all those reasons, few practice management consultants recommend winding down. "You should at least put your practice on the market and see what happens," advises Leif C. Beck of The Health Care Group in Plymouth Meeting, Pa. "It makes no sense not to try selling."

Sell to a hospital. "Increasingly, hospitals are doing the buying," says Steven B. Enright, a financial adviser in River Vale, N.J. "You may want to look into that possibility first."

There are drawbacks, however. If you retire, the successor the hospital hires may not give your patients the personal attention that you did. If you go to work for the hospital and are paid a percentage of your collections, your income may take a hit. Many practice management consultants feel that hospitals don't do a good job of billing and collecting for physicians' services, or managing their office staffs.

Then there's the psychological switch from private practice to employment "Think twice about accepting a job," advises retired internist Walter E. O'Donnell of Gloucester, Mass. "You'll get rid of some hassles, but it's not an easy adjustment for somebody in his 50s or 60s to start having a supervisor watch over him."

Hire an associate who'll buy you out. This way, you can taper off for a few months to a few years while your patients get to know their new doctor. You can also avoid all the work involved in closing down your office, as detailed in the accompanying article.

This option could be more palatable than working for a hospital, because you'll retain your autonomy. On the other hand, you could have trouble finding a doctor interested in taking over a solo practice long enough to buy you out, what with the "bigger is safer" mind-set of the '90s sending more doctors into group practice.

Merge with, or sell to, a group. Many large groups are snapping up small practices to serve as satellites. This would not only let you stay in private practice but also free you of many administrative responsibilities. And if you retire, the group could provide a home for your medical records, notes Health Care Group consultant Sandra McGraw.

On the minus side, if you stay on, a merger could force you to change your practice style and pace. Chances are that with a large group, you'd become more heavily involved in managed care. Also, you'd be expected to fit into the group's "culture" and forfeit a certain degree of independence.



to buy you out, it's a nice gesture to offer to help your assistants find similar jobs with colleagues or at your hospital, ideally to begin the day after you quit. For employees who don't latch onto a new job quickly, the advance notice will also allow time to switch their group health insurance to individual policies. Write each of them a letter of recommendation.

Also, determine how much extra pay you'll owe them for unused vacation time. If you're selling your practice to another physician or throwing in with an established group, determine whose responsibility such outlays will be.

Make sure your malpractice protection will continue. In general, this will happen automatically if you have occurrence coverage. Just to be sure, check your policy.

However, if you're like the majority of doctors, you have a claims-made policy. To keep on being covered after retirement, you may have to buy tail insurance, also known as a reporting endorsement. Many carriers waive the premium for retiring doctors who satisfy certain conditions. Typical is the Illinois State Medical Inter-Insurance Exchange, which does this for physicians aged 55 or older who've been with the insurer for at least five consecutive years.

The cost of tail coverage varies greatly, depending on specialty and part of the country. Count on its being at least the following year's regular premium, and perhaps twice that amount or more. Find out well ahead of time what your carrier will

charge, whether it will accept installment payments, and when the money will be due, so you'll have the cash available when it's needed.

At least two months ahead: Delve into the details

Whatever your plans, notify your state board of medical examiners. Tell the board whether you plan to practice in any other jurisdiction and whether you want to keep your license active or inactive.

Send word to your county and state medical societies, too. Be sure somebody at your local medical society knows where your patient records can be located. And even if you aren't a member of the American Medical Association, the organization needs to know your new professional status. It will use the information to update its Physician Masterfile.

Contact the Federal Drug Enforcement Agency and find out its procedures for turning in your DEA registration, along with unused DEA forms and controlled drugs. If you'll need your DEA registration, the agency will want your new address.

"Drugs that aren't controlled substances can be sold just like other supplies," says Chicago-based practice consultant Karen Zupko. "Sometimes a pharmaceutical company will take back unopened stock if it hasn't expired. Ask your dealer."

If you're retiring, check on what insurance and other benefits your professional organizations provide,

and decide whether any of them need to be replaced out of your own pocket. You probably won't need to continue your life and disability insurance. But group health insurance will still be important if you're retiring before age 65 or if your spouse still has a few years until Medicare kicks in.

Don't forget all the business insurance policies you'll want to cancel or transfer to the doctor or group that buys you out. There's fire and theft on your office, and liability insurance on the property. Whether or not this coverage is all under the same policy, keep it in force until your office is actually vacated—not just the last day you see patients there.

Keep your workers' compensation insurance in effect as long as anybody is still on your payroll. The same goes for any disability insurance or office-overhead insurance you carry. Then find out whether you're due a refund on the unexpired portions of those policies.

Several weeks before you leave practice, have your office manager or insurance clerk contact all the third-party payers you deal with—Medicare, Medicaid, Blue Shield, commercial carriers, PPOs, and HMOs—and get instructions for turning in or changing your provider numbers. If payers will still be sending you payments after you close your office, make sure they know where to mail them.

You may want to arrange with one of your front-office people to collect your mail, deposit checks, and keep your bookkeeping up to



RETIREMENT

What's your practice worth?

The practices in most demand these days are in primary-care fields. If you're a specialist and depend on referrals, expect trouble selling.

Either way, your practice may fetch a lot less than it might have a few years ago. Chicago attorney Jamie Stuart attributes the decline in value to the rise of managed care. "If all the care you give is managed care, all you own is contracts," he notes. "Most contracts aren't transferable. Your successor will have to re negotiate new ones on his own."

For this reason, a traditional attraction of a practice purchase - its patient census - is quickly fading in importance. Leif C. Beck, of The Health Care Group, which originated the Goodwill Registry, a respected guide to practice values, concedes that "the value of good will is much more conjectural than it used to be." In some areas, he says, good will may have no value, while in others it may range from 30 percent of annual practice gross (for a practice in a referral field) to 40 percent (for a primary-care practice).

Besides managed care and other health-reform activity, the federal government's enforcement of Medicare and Medicaid fraud-and-abuse regulations is depressing practice values. Hospitals are often reluctant to pay for anything that isn't a tangible asset - and that, of course, affects their decision to pay for good will. Some experts suspect that hospitals sometimes partially compensate for that by inflating the value of hard assets.

The message that practice values have dropped seems to be getting across. One surgeon, for example, recently agreed to a sale price of \$160,000 - barely more than a third of his annual gross. Acknowledging that he has seen other physicians set much higher prices, sometimes at twice annual gross, he considers his own price "modest but realistic." He adds that greedy physicians aren't likely to sell as fast as he did.

date for a specified time. The employee is generally paid on an hourly rate for whatever time this takes. But if that doesn't seem practical, you may be able to arrange with your bank for a lockbox service, available at most large commercial banks, according to Judith N. Aburmishan, a Chicago area accountant and practice management consultant. The bank assigns you a post-office box number. You notify insurance carriers

and patients with unpaid bills of this change of address. Once a day, the bank picks up your mail, opens it, and posts any payments to your account. At least once a month, the bank mails you all the explanations of benefits and other correspondence. While there's a fee for this service, it may be less than you'd pay the employee, Aburmishan says.

Two months before closing, or whatever notification period is specified in your office lease, tell

your landlord you won't be renewing. Also, make arrangements to turn in any leased equipment. Tell the local utilities when you plan to vacate and will need a final meter reading. Cancel (or forward) any magazine and journal subscriptions that come to the office. And let the post office know your forwarding address.

After you close down: There's still more to do

While you won't have your practice's patients, you'll have their medical records if you retire. Many practice management consultants recommend holding on to all original charts indefinitely - not only in case of a malpractice suit years later, but also because you could be audited by Medicare or Medicaid. Also, if you've treated children, they'll need access to their immunization records.

But where to keep all those charts? They'll clutter up your attic or garage. You also may not want the work and expense of copying them and forwarding the copies to other doctors.

One good bet is a commercial storage facility, usually listed in the Yellow Pages under "Office Records Stored." To archive a doctor's medical records, on such facility in New Jersey charges 22 cents per 15-inch-long box per month. If you drive up with 200 boxes, for example, it will cost \$44 a month to have them bar-coded and filed away. "Access is no problem," says



a spokesman for the facility, "but there's a fee of \$1.70 each time we pull a box for the customer, and an \$11 fee to deliver a record to him." Archive companies will also copy records for you.

Another option is to have your records microfilmed; many archive firms will do that, too. The cost up front is high, but you'll pay far less for storage.

A third possibility is rental of a "mini-storage" space. However, archiving or microfilming is likely to be a better deal. In mini-storage, you'll typically pay \$64 to \$82 a month for a 5-by 10-foot room.

Back up computerized patient-account records on diskette or tape, advises consultant Karen Zupko. If your practice isn't computerized, keep the current year's paper records until tax-filing deadline two years hence— for instance, you'd hold on to 1994 accounts until April 15, 1996. This is to let patients verify medical expenses claimed on their tax returns, and to let them file amended returns.

There'll be other records to keep: Save all your old malpractice policies until all statutes of limitations have unexpired. Employment and earnings records generally must be kept for three years; your accountant or lawyer can tell you what's required in your state. Federal law requires you to keep records of employees' on-the-job exposure to bloodborne pathogens for the duration of employment plus 30 years, according to Mark Kropiewnicki of The Health Care Group in Plymouth Meeting, Pa.

Keep your office checking account active for three months or so, to allow you to pay any bills that straggle in. Once most checks have shown up on the monthly bank statements, you can close it.

Finally, decide which services to keep in place. If you've planned carefully and notified patients early enough, you shouldn't have to keep your office open or pay assistants,

says Karen Zupko. However, she suggests keeping your answering service for three to 12 months, to redirect calls. "You can write the operators a short script to read, telling patients whom to call for copies of records, or other doctors how to reach you," Zupko says. And so that patients can call to get their records, keep your Yellow Pages listing for a year after you close.

One doctor's goodbye to his patients

Your farewell letter to patients should include such things as the date you're leaving and how patients can obtain their records and continued care. But the letter's style and warmth depend on you—and on how you ran your practice.

"That may vary by specialty and by where the practice is located— in New York City or a small town in Nebraska," notes Chicago management consultant Karen A. Zupko. The following letter from one OBG specialist is markedly warmer than the letters used as examples by most medical societies.

An open letter to my friends and patients:

After 40 years of practicing obstetrics and gynecology, I have decided that it is time to retire from patient care as of Dec. 31, 1993.

I have truly enjoyed caring for you and your family, and because your welfare is my utmost concern, I wish to make this transition as easy and efficient as possible for you. As you know, I have practiced most recently with Drs. Melvin Gerbie, Michael Halpem, Howard Arof, Mary Ellen Fausone, and Nanette Rumsey. They have been exceptional partners as well as superb physicians, and I firmly believe they will continue to give you excellent medical care. If this does not meet with your approval or needs, we will be happy to arrange for transfer of a summary of your records to whomever you designate.

The safe delivery of newborn babies has been the most exhilarating experience in medicine for me. The care of women through all life's phases has been most fulfilling, and you have helped to make it so.

Most sincerely,

Albert B. Gerbie, M.D.

A monthly report of current and ongoing activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.

CREDENTIALING TASK FORCE

January 18, 1995, 7:30 a.m.

Carol Walker brought copies of results of the AAMSE-SIG meeting including guidelines for preparing applications in compliance with JCAHO and NCQA standards. There is significant interest on a national level in standardizing and streamlining the credentialing process. Dr. Mains asked everyone to read over the materials prior to the next meeting.

This meeting consisted of going through the draft credentialing application page by page using a checklist of proposed changes (submitted to staff prior to the meeting) as a guide. Each item was either approved, not approved or identified as needing further discussion. Other items for change not included on the checklist were brought up during this process. Broader issues identified and earmarked for further discussion included:

- Health related questions
- Definition or use of phrase "pertinent documents"
- Discussion and improvement of questions regarding specialty/board certification
- Decision on including an "optional information" page and what information would be sought (i.e., who to call in an emergency, etc.)

Thursday, February 2, 1995

Site Surveys Conducted
Colorado Foundation for
Medical Care Approved

Columbine Psychiatric Center
Approved

Dr. Dernovsek pointed out to the Committee that strict interpretation of the guidelines for accreditation decisions would place this organization at full, one-year accreditation. After discussion and review of the criteria for accreditation decisions, it was decided to leave the accreditation at full, two years since joint sponsorship is not applicable in this case and a one-year accreditation would be more punitive than helpful. Additionally, Lorraine pointed out that several issues were already being addressed by this institution, indicating that they are taking comments from surveyors seriously.

McKee Medical Center
Delayed

Unable to review this survey, as the report was yet to be completed. It will be placed on the May 4 agenda.

Dr. Stahlgren attended the recent Alliance for CME Conference in Phoenix, and he made some overall comments about his experience. A discussion then took place among committee members regarding the current CME environment, the apparent reduction of physician involvement, etc. It was suggested that a CPEA meeting be planned to continue this discussion in-depth and in the absence of normal CPEA business. Staff will investigate feasibility of an extra meeting and budget impact. A decision will be made at May 4 meeting.

The Accreditation Council for CME (ACCME) has recently adopted a requirement that we have a

procedure for handling complaints. A draft procedure for input and approval was provided. It was approved with one correction at Item II: CMS Staff AND CHAIR will review the complaint/inquiry...."

As part of House of Delegates action to increase accreditation fees and become more self-supporting, fees for accredited organizations who offer jointly sponsored activities were approved. This fee, payable to CMS, is to a) cover costs for staff time and increased work required of surveyors; b) is a "tax" to remind people that there are responsibilities involved in entering into jointly sponsored arrangements. There have been ongoing problems with accredited organizations not providing adequate oversight in these activities. A charge of \$200 per activity or series up to \$1000 per year was to be assessed for those accredited providers who are involved with joint sponsorship. Personal statements and letters from accredited providers prompted a review of these fees including budgetary impact to them, what service is being provided in return, etc. It was discovered that there *may* have been *some* misunderstanding in interpretation of these fees as originally implemented. After discussion of the original intent (i.e., that the fees have a cap of \$1,000 with no additional costs when 6 or more activities have been sponsored, that it was expected the fees would be passed onto the nonaccredited organization, etc.) and clarification of same, it remained a concern that some organi-

zations being jointly sponsored would not be able to afford these fees. As a compromise, the Committee recommends that new fees be implemented as follows:

\$200 per activity or series (i.e., case conferences, multiple offerings centered on a theme, etc.), up to 5 activities or \$1,000 with no additional charge for 6 or more CME events being sponsored and to be assessed per survey cycle (as opposed to the previous per year). A survey cycle is from 1-4 years, depending on the duration of accreditation awarded to each organization. This recommendation will be forwarded to Health Affairs Council for action.

As part of an ongoing discussion on individualized learning and how this Committee can respond to these activities with our accredited organizations, Dr. Carey has a 10-15 minute presentation on the process of individualized education. This was postponed since he was unable to attend this meeting.

Lorraine revised the survey report and accreditation application forms, sent them to five selected committee members and surveyors for input, and submitted for committee review, input and approval. The application was revised to remove cumbersome and unnecessary information (particularly in Essential 6) and to more clearly state needed information. The survey report form was adapted from the one used by the ACCME. The current form is not well-received by surveyors, and early indications are that the revised one is more favorable.

Both forms were approved with flexibility given to staff for further revisions as long as they remain in compliance with the Essentials.

Resolution 320: *ACCME Policy Re Approval Period for CME Sponsors* asks the AMA to request that the ACCME allow states to accredit for up to six years as opposed to the current four years.

CME Report I-94: *Physician Credentialing and Privileging* discusses the role of CME and the accreditation process in developing guidelines for procedure and skill based CME.

Although not discussed, it was requested that discussion take place at the next meeting on current trend to deny privileges for some basic procedures that have not been performed by a physician for a certain period of time. (For example, appendectomies, spinal taps, etc.) The issue being whether CME has a role in these instances, and if so, in what capacity.

A letter from Swedish Medical Center was received. They have withdrawn their CMS accreditation and will be operating under the HealthONE national accreditation program.

February 15, 1995

Dr. Buckley briefly reported on Copic's recent purchase of Gadrian Corporation.

After discussion, it was voted to approve the wording used by the Colorado Board of Medical Examiners in their licensure application.

Next Meeting May 17, 1995, 7:30 a.m.

Sick of doctors' rude behavior

Although most patients realize that there are unpredictable factors which lead to delays in being seen by a physician, we are hearing more and more anger over the perception that many physicians *never* see patients less than an hour or more after their scheduled appointment time. One example of that anger appeared in the March 2, 1995 *Miss Manners* column, by Judith Martin, as submitted to *Colorado Medicine* by Mark P. Hayman, MD of Strasburg, Colorado.

Dear Miss Manners: As I understand it, when two people have an appointment, whether for business or social purposes, and one of them is unable to meet the other on time, it is that person's responsibility to notify the other of the delay.

Is this indeed the rule, and, if so, are physicians exempt from it? I have spent many hours in physicians' waiting rooms and I have yet to have a physician's office phone me to warn that the doctor is running late.

In self-defense, I have taken to phoning the doctor's office first, to make sure she is running on time before leaving for the appointment. When I recently tried this, I was told that while my gynecologist would not be able to see me on time, if I were to arrive late, I would be put in the queue behind the patients who had arrived earlier, regardless of when my appointment was.

I brought this up with the doctor herself (after a 45-minute wait in the waiting room), and her defense was that the other patients would be irritated if I were to wait in my own office (and get some work done), arrive at a time when I could be seen, and then be shown in before them.

This seems to me a curious and self-serving view of etiquette. Rather than invest the time and effort to treat all patients properly by phoning them if there is to be a delay, instead insist on mistreating all patients equally.

I understand that in a medical practice, there is an unavoidable variability in the time required to attend to each individual properly, and I would not complain about a 10- or 15-minute wait. But if the doctor has fallen significantly behind the appointment schedule, I see no reason why she should not be held to the same standard of courteous behavior as the rest of the business and social world.

Gentle Reader: Miss Manners doesn't want to hear the outrage from physicians and their staffs, along with their high-minded justifications about saving lives and the patients' money, that will be generated by your complaint and Miss Manners' agreement.

But the fact is that these people have presumed outrageously on the good nature of people such as yourself, who are ready to be accommodated about the occasional emergency and even the routine short delay. Everybody who wants good medical care will agree that some inconvenience might be necessary so that everyone gets the full attention needed, which cannot be exactly gauged in advance.

This does not, however, explain why virtually all patients seeking routine care are kept waiting for long periods of time, just about every single time they go to the doctor's. It has just come to be one of those institutionalized rudeness of the profession — the way opera singers are indulged for having tantrums.

Perhaps it is the patients themselves who need to alter this unfortunate practice. Heaven knows that Miss Manners has tried to appeal to doctors to do this voluntarily, but without noticeable results.

Because your doctor has presumed to speak for the other patients — suggesting an unfair scenario, in which the other patients would be led to believe that you merely walked in late and got served out of turn — perhaps you should ask them to speak for themselves. A waiting room caucus, in which people documented the inconvenience each had, and asked together for a change in the system, might make more of an impression.

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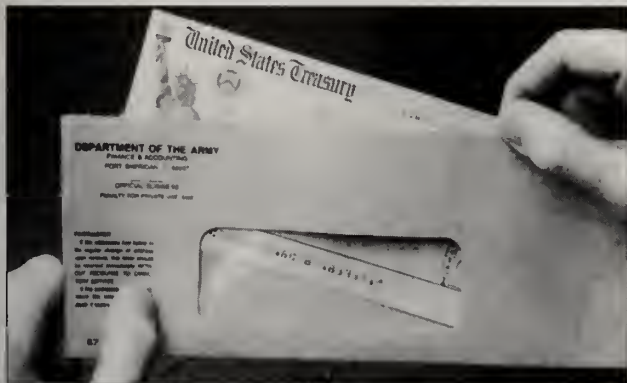
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H and Surgery in Uganda

Lee Gordon, MD, Fort Collins, Colorado



*Operating Theatre
in Kampala, Uganda*

"Catch a fish for a man and you feed him for a day, teach him to fish and feed him for a lifetime."

This Chinese proverb reflects accurately the mission of teaching as opposed to providing service (operating). In a trip to Mulago Hospital and Makerere University School of Medicine in Kampala, Uganda. I joined Dr. Allen Bach of Seattle, Washington, and two scrub nurses in forming a team for hand surgery and spent approximately 5 weeks in Uganda, in November, 1993. Our mission was to form a "scout team" for the American Society of Surgery of the Hand to determine if Uganda was an appropriate place to send full time hand surgeons for a third world experience.

Uganda is in east central Africa along the equator. It is about the size of Oregon with a population of 17 million people. There are currently only 5 Orthopaedic surgeons in the country. Two hold high government positions and do no clinic practice. The remaining three are in various states of training. The orthopaedic program is in excellent hands with Dr. Rodney Belcher, an American orthopaedic surgeon and various touring western orthopaedic surgeons. Dr. Bach and I were the second and third visiting hand

surgeons in Uganda. One additional hand surgeon has followed us approximately 6 months ago.

Uganda was liberated from the British in 1962 and then went through a period of the so-called "dark years" under the terror of Idi Amin and Obote. You can still see the ravages of the previous civil wars in the countryside and in the destroyed infrastructure of the country. English is the official language. The people are very warm and gracious toward all Westerners and in particular Americans. The country has been relatively stable under a military dictator since 1986. They have recently had their first democratic congressional elections.

Our intent was to teach hand surgery, operate on selective cases and recommend Uganda as a place for volunteer physicians interested in hand surgery in the third world. There are excellent orthopaedic operating facilities and an excellent system to triage the appropriate patients to hand surgeons. The remainder of Mulago Hospital is



Nine-year-old Ugandan child with ① polio, ② radial club hands, ③ intestinal worms.

NOTES FROM THE FIELD

quite primitive by our standards, however, the orthopaedic theatre is separate and possibly the best in sub-Saharan Africa. It is air-conditioned, well lighted, and generally has a good amount of supplies, though deficient on small sutures and, as in all of Africa, sometimes has no electricity, water, instruments, etc. Adjacent to the hospital is the Mulago guest house which has been renovated by the U.S. Agency for International Development and Health Volunteers Overseas for housing of volunteers.

During the month that we were there our lecture schedule included the following: Two grand rounds at the medical school, first was on *Wound Coverage* and second was *Fractures of the Upper Extremity*. We gave a two day seminar on applied anatomy of the hand at the anatomy department of the school of medicine. We gave a minimum of two seminars a week to either the

radiology, surgery department, or orthopaedic department. We taught on ward rounds to the orthopaedic staff therapists, orthopaedic technicians and nursing staff. We gave seminars, lectures and surgery at up-country clinics at Mbale, Mbarrara, and Masaka. During the month that we were there we performed approximately 30 cases. These consisted of burn contracture release with skin grafting, congenital anomalies, infections, posttraumatic deformity, tumor excisions, one case of rheumatoid arthritis and one tendon transfer for radial nerve palsy. Ninety percent of the cases were in children. There is a very high HIV positive titer in the population, some think as high as 35 to 40 percent of the population. You can see the effects of AIDS in the middle aged population. The loss of the native faculty doctors is attributed to the civil wars, death from AIDS and immigration to the west. The recovery of the

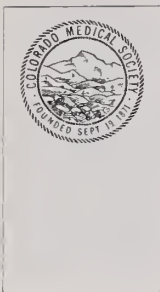
medical infrastructure will take several "lifetimes" to repair and reconstruct. Small steps made by individuals in time will lead to giant progress in their medical delivery system.

"The loss of the native faculty doctors is attributed to the civil wars, death from AIDS and immigration to the west. The recovery of the medical infrastructure will take several 'lifetimes' to repair and reconstruct."

For more information, contact: Health Volunteers Overseas, 202-296-0928



Debridement of burn wound and amputation of hand in Kampala operating room.



People with Kidney Disease May be Covered by Medicare

by Tom Przytarski

Social Security Manager in Denver

If your patients need dialysis treatments for permanent kidney failure or a kidney transplant, they may be eligible for Medicare - no matter what your age. People who have begun a regular course of dialysis or have had a kidney transplant are eligible for Medicare if:

- they are receiving Social Security or Railroad Retirement benefits (or they have worked long enough to be eligible for those benefits); or
- they worked for the federal government and paid Medicare taxes; or
- they are the spouse or dependent child of someone who meets any of the above requirements.

Medicare Part A helps pay for inpatient hospital costs associated with kidney transplant surgery, laboratory tests, home dialysis equipment, and the supplies and other services associated with such treatment.

Individuals enrolled in Medicare because of permanent kidney failure have the same coverage as anyone else who is on Medicare. That means Medicare will help pay for other hospital and medical services you may need even if they are

unrelated to your kidney disease.

There is no monthly premium for Part A coverage, but there are "copayment" charges (the amount of the bill the patient has to pay) for long hospital stays. There is a \$46.10 monthly premium as well as a \$100 annual deductible and copayment charges for the services covered under Part B. If your income is low enough, your State might be able to help pay your Part B premiums and some of your other out-of-pocket Medicare expenses. Check with your local welfare or social services office about the Qualified Medicare Beneficiary (QMB) program.

People who have begun a regular course of kidney dialysis or who are contemplating kidney transplant surgery should apply for Medicare by contacting Social Security. To save time, you can set up an appointment for an interview by calling Social Security's toll-free number: 1-800-772-1213.

For more information, ask for a copy of the pamphlet, *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*. People can also obtain the booklet by writing to the Consumer Information Center, Department 519-Y, Pueblo, CO. 81009

Meandering Streams

1994 was a good year for reflection for a lot of physicians: the economy wasn't all that good; medical practice was taking a downer because of the great hullabaloo about a national health care plan; a lot of Americans were thinking about

"the good old days".

Actually, Dr. Marvin Cameron of Aurora had started his reflections some time before that; he is semiretired from family practice and emergency medicine and started writing in earnest a couple of years ago.. His first literary work is a little book entitled "Meandering Streams", a collection of short stories about his boyhood and what it is like becoming a fishing addict at the early age of 8 or 9 years.. The book is illustrated with pleasing pen and ink sketches by Jana E. Schnoor.

Dr., Cameron was born in Comargo, Oklahoma, which has little to do with anything except that he may have got his taste for fishing in bass country, but did most of his developing in hill country where trout and northern pike, etc. abound. This makes the little book so appealing to Coloradans thinking of mountain streams this time of the year.

"*Meandering Streams*" (Silver State Publishing Co., P.O. Box 370330, Denver, CO 80237-0330, ISBN 0-944653-02-2) can be ordered by calling 1-800-453-8309. For information about the book, call 303/740-8811, or call Dr. Cameron's office at 303/364-8200.

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◆ MISCELLANEOUS

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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

They weren't necessarily the "good old days". They were just simpler, —at least in medicine.*



*Frederick J. Bancroft, MD; Denver.
11th CMS President, 1880-81
May 25, 1834--January 16, 1903
MD 1861, University of Buffalo*

***"... I'd have known at
least a minute earlier than
the cowboy if death were
imminent."***

F. J. Bancroft, MD

He was simply huge, six-feet-four and varying between 270 and 300-plus pounds, every pound of him famous for his infectious humor and continual joshing - famous also for his skill in diagnosis and surgery. He was as big professionally as he was physically, and his friends were legion. He even made a lifelong friend of truculent, warlike, Chief Colorow, with whom he exchanged practical jokes and whose gifts to the doctor are now prized by museums.

Dr. Bancroft arrived in Denver by stage in 1866, and he became a founder of the Denver and Colorado Medical Societies, the State Historical Society (President 17 years), the State Board of Health (President two years), Saint Luke's Hospital, Denver University Medical School, the Denver School Board (President many years), and he was usually either chief surgeon or local surgeon for every railroad serving Denver.

He'd had wide experience as a Union Army Surgeon, and he was the only Union doctor permitted (and reluctantly since Bancroft was a Connecticut Republican) to treat Confederate President Jefferson Davis' painful facial disease while the latter was a Union prisoner.

Dr. Bancroft was both a gourmet and a gourmand. A friend of similar tastes took him to dinner at the just-opened Brown Palace Hotel. Each consumed two dozen raw oysters as an appetizer, then a large roast turkey was served as the entree. Dr. Bancroft looked mournfully at his host's choice and said "A turkey is such an awkward bird, a little too much for one and not enough for two." The

host immediately ordered a supplementary roast chicken!

His buggy was built with extra heavy springs on the driver's side - he'd broken the springs of others, including that of his friend Dr. Jesse Hawes of Greeley, so when Dr. Hawes again called him in consultation he met Dr. Bancroft at the railway station with a hay wagon, much to the amusement of all concerned, including many bystanders.

Once he had to amputate the leg of a cowboy at Deertrail and ignored the patient's drunken brother who was swearing to kill Dr. Bancroft if his brother died. "Why worry?" the doctor said later, "I also wore a six-shooter and I'd have known at least a minute earlier than the cowboy if death were imminent."

He retired in 1899, suffering from diabetes, and spent his last four years in the warm climate of San Diego, California.

** I felt called upon to reprint this wonderful article from the Rocky Mountain Medical Journal (Colorado Medical Society Celebrates 100 Years 1871 - 1971; H. Sethman, April, 1971, Vol. 68, Number 4) because of excerpts from a letter written by Dr. Jesse Hawes of Greeley. In the letter, Dr. Hawes threatened to shoot an Alabama doctor if he came to Colorado. As noted, Dr. Hawes was a close friend of Dr. Bancroft, and was CMS's 15th President.*

B. Pierson



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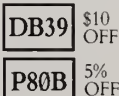
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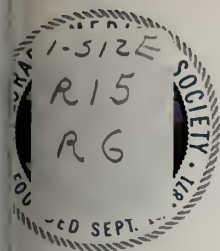
COLORADO MEDICINE

VOL. 92

NOS. 6

Located in pocket





COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

1995

Volume 92, Number 7



COLORADO DIRECTIVE

NOTICE

To all physicians who ascribe to being
"patient advocates".

**Withholding Cardiopulmonary Resuscitation:
how important is this to you?**

If you are truly a "patient advocate" you need to know what your patient needs to complete the "Colorado Directive." You are the only source of this authorization, so your patient needs you!

Colorado Medical Society can not do it. The form must be obtained through YOU and ONLY you!

This is not a clinical matter; this is a practical matter of which you, Doctor, need to be fully aware. If you are not, your patient will endure many frustrations and possible hardship. Read this issue carefully; it is your professional duty to know what and how, when it comes to the "Colorado Directive".

See the story on page 229 for very simple directions on how you can be a real friend to your patients and how CMS can then help you.

This Issue:

Quinn Elected to AMA Constitution & Bylaws Committee

Candidates for Colorado Medical Society Elections

New Communications Era for CMS Leadership and Members – President's Letter

CMS/CHMOA White Paper – Special Insert in this issue

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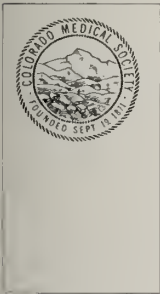
July, 1995

Volume 92, Number 7



Cover Story

Being a patient advocate means helping combat the ignorance of Colorado's CPR Directive; what it is, and where to get the forms. See page 229.



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Dr. Williams' career reflects his commitment. He worked as a pharmacist, then went back to school and earned his MD. He paid for medical school by committing to work three years at a community health center — Southside. Nine years later, he's still there, still giving.

The Sharing the Care program donates Pfizer's full line of single-source pharmaceuticals to medically uninsured, low-income patients of federally qualified centers like Southside, in support of those who, like Dr. Williams, are part of the cure.

Sharing the Care: A Pharmaceuticals Access Program is a joint effort of the National Governors' Association, the National Association of Community Health Centers and Pfizer.



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CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax[®]
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

Fraud Alert!

The Better Business Bureau has issued a bulletin warning physicians that their patients may be obtaining prescription drugs illegally by mail. The BBC says certain mail-order houses advertise in popular American magazines, offering toll-free ordering of medications by credit card, often at greatly reduced prices and apparently without a prescription.

This is obviously illegal, but may also be dangerous. According to the BBB, "The quality of these so-called 'foreign versions' of prescription drugs is often

unknown. In several cases the drugs were counterfeit, lacking any real similarity to the approved drug." Even if consumers obtain the correct drug, the directions are often inadequate, increasing the danger of severe adverse reactions, including death, according to the Food and Drug Administration.

If any of your patients have obtained these drugs, you may have them checked by the FDA by calling 303-236-3000. If you or your patient have any questions about an advertised product or company, contact the Better Business Bureau at 303-758-2100.

Colorado Physician Network

1,508 physician members contributed \$151,000 to pursue feasibility of a physician-directed statewide network. The Colorado Physician Network, Inc., was established as a separate transitional corporation on January 20, 1995. The members of the Board of Directors are Drs. David C. Martz, Thomas J. Allen, Stephen G. Batuello, Louise L. McDonald, Wm. Carl Bailey, Jack L. Berry, Joel M. Karlin, Muryl L. Laman, Terrance J. Sullivan, and M. Robert Yakely. David Ginsberg of Santa Fe, New Mexico, has been retained as consultant. Several meetings have been held since February and six potential partners have been evaluated. A final selection has been made and a letter of intent has been signed. A public announcement is anticipated soon.

CMS, HMOs Reach Historic Agreement

Leigh Truitt, MD, had been hired as the CMS liaison physician and is hard at work already developing "report card" parameters and clarifying individual HMO policies. The concepts of the "White Paper" are being implemented. The CMS/HMOA Joint Committee has been expanded to include six CMS member physicians,

and it will continue to meet on a regular basis to pursue additional unresolved issues of mutual concern. Numerous organizations and other states have requested copies of the White Paper. Note that the entire paper has been published in this issue of Colorado Medicine.

Dr. Reggie Washington Receives National Honor

Reginald Washington, MD, an eight-year member of the CMS, was given the American Heart Association's highest award at AHA's recent meeting in Dallas. Dr. Washington was named Physician of the Year by the national organization.

Dr. Washington is past president of the American Heart Association of Colorado and currently serves on the AHA National board of Directors. He is one of the few physicians who have been involved with prevention of atherosclerotic disease beginning in childhood and he has been especially active in scientific evaluation of exercise in children. He was a member of the AHA's Council of Cardiovascular Disease in the Young, and chaired the council's committee that revised the guidelines for exercise testing in the pediatric age group.

Dr. Washington practices pediatrics and pediatric cardiology at Presbyterian/ St. Luke's Medical Center in Denver. His wife, Faye, is also an active volunteer with the Heart Association.



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, PC.

This column is not legal advice, but is for general information only. For help with specific problems, readers should consult an attorney.

National Practitioner Data Bank "Help Line"

The U.S. Department of Health and Human Services has created an "NPDB Help Line" at 1-800-767-6732. Follow the pre-recorded directions and eventually a friendly civil servant will answer your questions about the Data Bank. You can also request a copy of the NPDB Guidebook, a helpful and comprehensive reference which answers many of the most often asked questions about the Data Bank and its reporting requirements.

Here are a few interpretations of the Data Bank reporting requirements found in the Guidebook:

1. If a patient makes an oral demand for a refund for services, the resulting payment is not reportable to the Data Bank. If a payment is made based only on oral demands, no report is required. Only payments resulting from written demands are reportable to the Data Bank. Even if the practitioner transmits the demand in writing to the medical malpractice payer, the payment is not reportable, if the patient's only demand was oral. However, if a subsequent written claim or demand is received from the patient and results in a payment, that payment is reportable.
2. Individual practitioners are no longer required to report to the Data Bank payments they make on their own behalf. If the insurance company reimburses the practitioner for a medical malpractice payment the practitioner made to a patient (makes a payment in response to a medical malpractice claim or judgment), it is reportable, as long as the patient submitted the demand in writing.
3. If a practitioner personally refunds (from the practitioner's personal funds) a fee to a patient, the refund is not reportable to the Data Bank. However, if the refund is paid by an insurer or any entity other than an individual practitioner (including a professional services corporation comprised of a sole practitioner), the refund is reportable.
4. A waiver of a debt is not considered a payment and should not be reported to the Data Bank. For

example, if a patient has an adverse reaction to an injection and is willing to accept waiver of the fee as settlement, that waiver is not reportable to the Data Bank.

5. If a practitioner is dismissed from a lawsuit in consideration of a payment being made in settlement of a lawsuit, the payment will be construed as a payment on behalf of the health care practitioner and must be reported to the Data Bank. For example, a health care practitioner is named in a lawsuit. The practitioner agrees to a payment on the condition that his or her name does not appear in the settlement documents. The payment would be reportable to the Data Bank.
6. If an individual practitioner is not named in a medical malpractice claim or complaint, but the facility or practitioner group is named, the payment should not be reported, with one exception. If the named defendant is a sole practitioner identified as a "professional corporation", a payment made for the professional corporation must be reported for the practitioner.

While medical malpractice payers (such as insurance companies) must report payments made on behalf of physicians, dentists and other health care practitioners, they may not query the Data Bank. Health Care Practitioners may self-query the Data Bank at any time.

The Data Bank reporting requirements have tested the creativity of practitioners and their attorneys since 1990. The Guidebook attempts to clarify the rules and, in so doing, suggests some alternative means of resolving conflicts that make settlement more palatable.

Case Study: Insurance Coverage

This is the unfortunate story of Dr. Cecil Jacobson, a philanthropist of sorts and the owner of a fertility clinic in Virginia. It demonstrates just how broadly a court can interpret a carrier's duty to insure against and defend professional liability claim. It also proves the point that sometimes reality is stranger than fiction.

In 1992, Dr. Jacobson was convicted of 52 felony counts arising from various schemes designed to lure patients into his fertility clinic. During artificial insemination procedures he injected his own sperm into his patients, instead of the promised sperm of the patients' husbands or anonymous donors. Dr. Jacobson admitted that he intentionally inseminated patients at his clinic with his own sperm approximately once a month during the time period from 1976 to 1986.

As a result of these activities at least 6 civil suits were filed against Dr. Jacobson by the parents of children he allegedly fathered. The claims against the doctor ranged from medical malpractice and negligence to battery and fraud. The parents requested child support and other damages arising from Dr. Jacobson's provision of "professional services".

Dr. Jacobson carried liability insurance throughout

Medico-Legal News (continued)

the years that he "donated" semen to his own patients. Under his policies, the insurance company agreed to defend Dr. Jacobson and pay damages in any suit "resulting from ...[the] providing or withholding of professional services".

When Dr. Jacobson asked the carrier to defend the pending civil lawsuits, the carrier filed suit against Dr. Jacobson to rescind the insurance contract. The carrier claimed that Dr. Jacobson lied on the insurance application by not disclosing his fraudulent insemination activities; that intentionally and fraudulently using his own sperm to inseminate patients was not a "professional service" and thus was not covered under the policy; and that public policy precluded insuring a wrongdoer against the consequences of his intentional, fraudulent, illegal acts.

The insurance company argued that the acts from which the damages arose were Dr. Jacobson's production of sperm sample and his fraud and deception, which were not part of a covered "professional service", as that term was defined in the policy.

The trial court and the federal court of appeals disagreed with the insurance company, and held instead that the policy did provide coverage for the claims against Dr. Jacobson. "[W]hile Jacobson's production of sperm did not require any medical skill, the act complained of in the complaint was the fraudulent use of his own semen to inseminate patients rather than using the sperm of an anonymous donor or the patient's husband, acts which necessarily required the application of his medical knowledge and special skills in the act of inseminating the patients.

This case offers an interesting example of how courts can, in appropriate cases, stretch the traditional meaning of a "professional service" to find coverage. When it happens, the court is typically faced with an innocent and deserving patient on one side, and an impecunious doctor on the other. Although we do not know how successful Dr. Jacobson's business was before his troubles started, it's safe to say that after his felony convictions business suffered. Incidentally, by the time the opinion was published all but one of the patients' claims had been settled. **Reference:** *St. Paul V. Jacobson*, 48 F.3d 778 (4th Cir. 1995).

Sign Language Interpreters

Does the ADA require their presence at medical examinations of the hearing impaired?

The first case brought against a medical practice for allegedly failing to provide sign language interpreters to hearing impaired patients has been filed. The District Court for the Southern District of New York recently issued an Opinion and Order addressing certain jurisdictional and procedural questions. The

Opinion is interesting because it outlines the underlying facts upon which the lawsuit is based, and may offer some guidance for practitioners wishing to avoid similar litigation.

Mid Hudson Medical Group, PC, operates a large medical practice with 19 physicians and a staff of 90, who treat about 50,000 patients a year. Seven to ten of those patients are hearing impaired. The attorney General for New York State filed suit against Mid Hudson claiming that it refuses to provide interpretive services for these patients, and that these patients must therefore resort to note-writing and lip-reading to communicate with their doctors.

In 1993, a hearing and vision impaired patient asked Mid Hudson to provide an interpreter for his scheduled physical examination. Mid Hudson denied his request. The patient later hired his own interpreter and submitted the bill for his services to Mid Hudson for reimbursement. Mid Hudson refused to pay the bill.

This patient had several other contacts with Mid Hudson during which it consistently refused to provide or pay for an interpreter for this patient. During some visits, the patient asked for an interpreter to assist him in understanding care and treatment being provided to his daughter. All requests were refused.

On an apparent tip from the patient, the N.Y. State Attorney General's office conducted an investigation of Mid Hudson which included calls by two different investigators to Mid Hudson requesting interpreters for medical appointments. Both requests were denied.

The primary issue decided in the opinion relates to whether the N.Y. State Attorney General is a proper party to bring the action against the Mid Hudson Medical group. Mid Hudson also argued that the Rehabilitation Act (which predates the ADA) does not apply to Mid Hudson because it is not a program receiving federal funding, for purposes of the application of the Act.

The Court rejected both of Mid Hudson's arguments. On the first point the Court found that the State could sue in *parens patriae*, for all hearing impaired patients in New York. On the second, the Court found that the Medicaid and Medicare reimbursements Mid Hudson received to constitute "federal financial assistance", for purposes of triggering application of the Rehabilitation Act.

In effect, the Court kept the lawsuit alive for the State of New York and the patient. At trial the central issue will be "What constitutes effective communication between a physician and a hearing impaired patient, and under what circumstances auxiliary aids are necessary to make effective communication possible?"

Reference: *New York v. Mid Hudson Medical Group, PC*, 94 Civ. 4688

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Advisory Council on Health Programs for Women and Children

Regular monthly meeting.

For information call Suzette Clark at (303) 692-2421.

Colorado Department of Public Health & Environment

Long Term Care Advisory Meeting

July 11, 1995

Denver, Colorado

Janell Little, 303-692-2903

Colorado Department of Public Health & Environment

Air Quality Control Commission

July 20, 1995

Denver, Colorado

Janet Lenger, 303-692-3278

Colorado Department of Labor and Employment

Worker's Compensation Level II Accreditation

July 21, 22, 1995

Denver, Colorado

Faye Boyd, 303-575-8756

Colorado Physical Therapy Institute

Work Injury Prevention

July 20, 1995

Broomfield, Colorado

303-460-9129

Colorado Physical Therapy Institute

Cervical/Thoracic Spine

July 21-23, 1995

Broomfield, Colorado

303-460-9129

Colorado Department of Public Health & Environment

Rocky Flats Exchange of Environmental Information

July 25, 1995

Denver, Colorado

Robert Terry 303-692-3051

Colorado Department of Public Health & Environment

Pollution Prevention Advisory Board

July 25, 1995

Denver, Colorado

Parry Burnap, 303-692-3009

Prosper Meniere Society

Clinical Evoked Potentials and Intraoperative Monitoring Seminar

July 26-30, 1995

Denver, Colorado

303-788-4235

Montgomery Dorsey Symposium

Fifteenth Annual Montgomery Dorsey Symposium "The Fate of the American Health Care System: Perspectives from Key Players"

July 27-29, 1995

Beaver Creek, Colorado

Contact: (303)322-1523

Colorado Department of Public Health & Environment

Hazardous Waste Commission

July 27, 1995

Denver, Colorado

Laurie Simmons, 303-692-3325

Aurora Professional Home Health Nursing

Original Aurora — Aurora Home Health Care Agencies Open House

July 28, 1995

1470 Emporia St, Aurora, Colorado

Cathy McNamee, 303-367-4912

American College of Cardiology

Echocardiographic Symposium of 2-D and Doppler Echocardiography at Vail

July 31-August 3, 1995

Marriott's Vail Mountain Resort, Vail, Colorado

CME credits: 23 Category 1 AMA

Contact: 800-257-4739, FAX 301-897-9745

Colorado Department of Labor and Employment

Worker's Compensation Level II Re-accreditation

August to November, 1995

Denver, Grand Junction, Colorado Springs

Faye Boyd, 303-575-8756



PRESIDENT'S LETTER



David C. Martz, MD
President, 1994-1995

This has been an exciting year thus far at CMS. As you know from my prior "Letters", we have tackled lots of "big things" this year: the White Paper with the HMO Association, the CMS-initiated point-of-service legislative effort, the feasibility of a Colorado Physician Network (CPN), the complexities of collaborative practice with nurses, coalition building inside and outside the house of medicine, the creation of a universal credentialing form... the list goes on and on.

But at CMS - like most other relationships - "little things" also mean a lot. And for us - as for other relationships - communication is a very important "little thing". In the days ahead we will be putting special emphasis on expanding communication. Year after year your leadership has been encouraged to develop more effective "talk" between the officers and membership. It is a perennial dilemma: how do we stay up to date on your issues and concerns? How do you keep track of our efforts on your behalf?

It's time we try something different. Several ideas have surfaced as I have churned the possibilities in my mind while traveling Interstate 25 this year.

Leader's Digest intended as a frequent, fast-fact update, this one-page "bullet-style" communiqué will be FAXed to leaders every two weeks (Board of Directors, delegates, component and specialty society officers, council and committee chair persons). Each issue will cover up to half a dozen topics

of current activity - often including a request for your feedback - to keep local CMS leaders throughout the state very up to date. By the time you read this, the first three issues will have been transmitted to your leadership representatives in mid-June, late-June and mid-July. Armed with this resource, you may expect them to be a more effective conduit of information and opinion. So, seek them out and ask them "what's happening this week?" - and expect them to know.

The CMS Weekly - "A clipping resource of CMS". Challenged by the near-impossible task of keeping up with the plethora of medical issues in the public media, we have developed a clipping service for a limited number of CMS leaders. Gil Maestas of the CMS staff has been compiling all medically-related articles from the Denver Post, Rocky Mountain News, Denver Business Journal, New York Times and Wall Street Journal for the past year. Up to 25 pages of these clippings are prepared each week and provide a rich supply of current media background. Without having to plow through armloads of advertisement-laden periodicals, the nuggets of this week's news are at fingertip access. Not only does it become possible to be promptly informed, but also one may easily create files on key topics and thus be well prepared for informal discussions or major

"Let's Talk!"

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The CMS Weekly

PRESIDENT'S LETTER (Continued)

presentations. A recent week's collection included numerous articles on the ever-changing Metro medical mergers, an analysis of the demise of the Health Data Commission, access to prescription drugs in Mexico, a Rocky Mountain News article by Denver Medical Society President Barbara Reed, analysis of the problems confronting Blue Cross-Blue Shield of New Mexico, a report on Canadian attitudes about assisted suicide, status of the ebola virus epidemiology, and numerous other topics.

This resource might be useful to many members of CMS, and not just our key officers. We are looking into ways to provide this to any interested member as another "value-added service" of CMS. If you think it would be of use to you, please call Bill Pierson, Director of Communications &

Member Services at (303) 930-0418.

Internet Access We are currently considering a budget item for electronic mail in the year ahead. One possibility is a CMS forum through "Physician On Line" wherein anyone with a computer, a MODEM and a major on-line service (America On Line, E-World, Physician-On-Line, Prodigy, CompuServe) could access freely. The opportunities range from simple meeting announcements and agendas to polling the membership on legislative issues, CMS policy dilemmas, and practice surveys. Yet another possibility is real-time two-way communication with officers or staff.

Tell-Dave (303) 930-0420. My Voice Mail at CMS is always at your service, 24 hours a day. Established last September as a mechanism to tell me personally of your concerns, it was heavily

used during the months of the "mandatory" CPN assessment and to a lesser degree throughout the year. I have attempted to respond with a personal letter or a phone call to every message received, though I must admit that a call or two may have slipped through the cracks. In any case, I have been grateful for the candor of your comments, and hope that you will continue to utilize this avenue of correspondence in the months ahead.

There may be other communication tools which we should consider. If you have suggestions, let me know - any viable option will be considered.

In any case, keep talking "with us"... talking "about us" doesn't help. We may not all agree on every point, but our diversity gives us strength - our similarities create commitment. So "let's talk". . .

LEGAL UPDATE

Anti-Competitive Conduct

Pursuant to Colorado law, a permanent, independent, 5-member committee of the Board of Medical Examiners was established known as the Committee On Anti-Competitive Conduct. No member sits on the Board of Medical Examiners; four members must be actively engaged as licensed medical practitioners in Colorado. A Committee member may not practice in the same medical sub-specialty as any other member nor practice in the same medical location as the county in which any other member has his or her primary practice. The fifth member of the Committee must be an anti-trust attorney licensed to practice law in Colorado. Any physician who is subject to a final action by a governing board which results in the denial or termination of privileges or eliminates or restricts membership or participation in an organization and who believes that such action resulted from unreasonable anti-competitive conduct shall have AS HIS SOLE AND EXCLUSIVE REMEDY direct review of the record by the Committee.

Review is initiated by filing a complaint (claim) not later than 30 days after receipt of a notice of final action by the governing board denying or limiting participation by the aggrieved physician. The complaint must set forth all material facts. The governing board and professional review committee then have 30 to file their verified answer (response). The Committee may dismiss the complaint if it finds that the facts alleged would not substantiate a finding of probable cause that the governing board's action resulted from unreasonable anti-competitive conduct. If the Committee finds that such probable cause exists, it must schedule a hearing. The Committee may, in its final order, disapprove and set aside the final action of the governing board if it determines from the evidence that the board's determination resulted from unreasonable anti-competitive conduct.

The final administrative action by the Committee may be reviewed by the Court of Appeals. In the alternative, any party aggrieved by the final action of a governing board does have the right to seek a new trial on the merits in a district court (trial court) in Colorado.

*from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000*

The Committee is required to assess and collect all costs associated with its activities. The complainant is required to post a cash bond, or equivalent, of \$3000. Members of the Committee are immune from suit in any civil action based upon any proceedings or other official actions performed in good faith. This immunity extends to witnesses, consultants, and staff members.

Colorado statutory law includes the "Unfair Practices Act" and the "Colorado Anti-Trust Act of 1992". These statutory provisions are available to citizens and entities involved in trade or commerce in Colorado. It is critical that physicians are aware of the limitations imposed upon their rights to bring actions against other parties for anti-competitive practices pursuant to the anti-discriminatory statute discussed in this article.

For further information please contact:
A Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

EXECUTIVE DIRECTOR'S UPDATE



*Sandra L. Maloney
Executive Director
Colorado Medical Society*

I saw that on a sign the other day, advertising something, but even so, the statement is true: once you get a behemoth rolling, it's hard to stop. I think of this in relation to the "Study of the Federation" which has been going on for over a year. The "Federation" is the American Medical Association, and the AMA is like a train, with all its cars hooked on behind an engine. Each car is loaded with some group or organization's baggage. Once you get all this collection of ideas, philosophies, experiences, hopes and aspirations moving, it's hard to stop. It is also very difficult to change direction, because if you're lucky, the train will stay on the track you laid down, and the track takes the train in only one direction at a time.

The purpose of the Study of the Federation is to identify how medical associations can best meet the future needs and concerns of physicians, because, remember that the AMA is made up of numerous associations. In this identification effort, "the objective is to produce recommendations that redefine relationships in organized medicine in order to: 1) enable the medical profession to speak with one voice on critical issues; 2) create more efficient ways to accomplish work on behalf of the medical profession, and 3) minimize duplication of services by enabling each element of organized medicine to do what it does best". An ad hoc committee formed by the AMA Board created two deliberative bodies to conduct the Federation study—a Consortium (of which Dr. Dave Martz is a member) of some 200 members from

medical societies, and a 28-member Project Team. That's a tall order.

The Study of the Federation has just issued an Interim Report, and a broad consensus includes:

1. Increased membership and participation by physicians in all levels of organized medicine to make the Federation more responsive to the interests of patients and physicians.
2. Establish a new Federation of Medicine which is more collaborative, integrated, efficient, representative, and inclusive in order to meet the changing needs of physicians and their associations.
3. Existing types of medical associations (state associations, county societies, specialty societies, and the AMA) can serve as the basic building blocks for a new Federation of Medicine. There will be some changes within these organizations needed to ensure the success of the new Federation.
4. Representational and governance systems now used by all elements of organized medicine should be participatory, democratic, and reflective of the diversity of the membership.
5. Explore collaborative efforts and joint ventures to reduce costs, increase efficiencies and improve services.
6. Representational and economic incentives should be offered individual members to encourage further physician participation in organized medicine.

The Consortium concluded that the AMA is the logical element to serve as the framework for a new Federation of Medicine; however, the AMA will have to change in some ways to fulfill that role successfully.

Will we have our boxcar load of

It's hard to stop a train!



concerns and interests sidetracked, shunted off, parked or derailed, while the rest of medicine rolls on by? It could happen if we are not very careful. Colorado must have a strong, positive voice in the activities of the Federation of Medicine. I can't include here all the points of study of the Consortium, but I can say that we are on the very outer edge of change, on the cusp, so to speak, because wherever the Consortium takes us now we haven't much choice but to work with it, go with it and make it what we, the members of organized medicine, want it to be, pointing it in the direction we want it to go. This train is rolling and is pretty well up to speed. That's why CMS leadership and Colorado's AMA delegation posts are so important. They are our railroad agents, our conductors, some of them even engineers and switchmen.

Change is here. This train has a head of steam up, and we had better have a hand on the throttle **and** the brakes and be very mindful of where we want this train to go.

It's hard to stop a train!

Colorado Medical Society Colorado HMO Association White Paper on Physician Affiliation/Disaffiliation

I. INTRODUCTION

A number of factors have resulted in expansion or contraction of panels of physicians which contract with HMOs. Such factors include, but are not limited to the following: growth in HMO enrollment ; intense competition among HMO's and insurance carriers; FPO development; development of Physician-Hospital organizations; and Employer Report Cards (Health Plan Employer Data Information Set ["HEDIS"]). The affiliation/disaffiliation process has significant implications for the physician, HMO member and the HMO.

II. PURPOSE AND SCOPE

The purpose of this White Paper is to address issues of mutual concern arising in the affiliation/disaffiliation process among physicians and HMOs.

The Colorado Medical Society ("CMS") and the Colorado HMO Association ("CHMOA") recognize that the relationship between a physician and an HMO is voluntary and contractual in nature. It is not the intent of this White Paper to alter current contracting practices between HMOs and Physicians. This White Paper should not be construed as endorsing physician disaffiliation solely "for cause" or an adversary hearing process for disaffiliation.

CMS and CHMOA believe that issues arising among physicians and HMOs could be ameliorated by enhanced communication between physicians and HMOs. They wish to develop an alternative to the expensive and time consuming adversary hearing process, while emphasizing mechanisms for dispute prevention.

Affiliation/disaffiliation issues involving quality of care or professional competence of physicians which lead to termination " for cause " are outside the scope of this White Paper. Such matters have implications under both state and federal law.

This White Paper contains the views and commitments of CMS and the CHMOA. However, each organization is comprised of individuals whose adherence to the views stated herein may differ.

Some HMOs contract with groups of physicians (e.g. IPAs) which have primary responsibility for affiliation/disaffiliation actions. The recommendations of this White Paper are applicable to such groups of physicians as appropriate. The actions contemplated by this White Paper are recommendations which may or may not be adopted by an individual physician, group of physicians or each HMO.

III. RECOMMENDATIONS

HMOs and physicians recognize that two-way communication is a critical part of maintaining an effective working relationship in the provision of quality, cost effective health care to HMO members. The following recommendations are intended to enhance the communication process.

A. Contracting Standards.

Contracting standards should be developed for primary care physicians and each physician specialty. Such standards should be utilized in determining physician selection, retention and disaffiliation. The standards may include, but not be limited to the following: medical education; postgraduate medical training; board certification and eligibility; geographic location; office hours; hospital staff privileges, needs of HMO members for accessible and available medical care; number of members receiving care from the physician; results of patient satisfaction surveys; medical utilization factors based as much as practicable on objective data collection and interpretation; and the HMO's perception of a physician's ability to work collaboratively in a managed care environment. An HMO or physician group may change such standards from time to time.

White Paper on Physician Affiliation/Disaffiliation

(Continued)

B. Disclosure of Standards.

Contracting standards should be disclosed to current and prospective participating physicians and CMS.

Amendments to contracting standards should be communicated to participating physicians in a timely manner. Disclosure is subject to reasonable limitations to protect trade secret information.

C. Contracting Standards for Specialty Physicians.

Contracting standards for specialty physicians should be developed by an HMO in consultation with physicians within that specialty and primary care physicians.

At the request of an HMO or physician group, CMS will identify specialist physicians from the community, academic institutions or specialty societies who will be available to consult in the development of contracting standards for specialist physicians.

D. Data Collection and Analysis.

Specialty specific credentialing and contracting methodologies for data collection and analysis should be developed in consultation with physicians within that specialty and primary care physicians. Data systems for credentialing and contracting with primary care physicians should be developed in consultation with primary care physicians and appropriate specialist physicians.

E. Evaluation of Physicians.

Each physician should be provided periodically (as appropriate for the nature and amount of data and the volume and scope of services provided by the physician for the HMO or physician group) with data regarding his/her performance within the HMO relative to stated criteria and to an appropriate group of comparable physicians. Upon presentation of such data, each physician should work cooperatively with the HMO or physician group to improve performance.

F. Specialist Department Chairperson.

HMOs should consider utilizing a "department chairperson" or specialty consultant for each physician specialty. As determined appropriate by the Medical Director of the HMO or physician group the department chairperson or specialty consultant would act as an intermediary with specialty physicians to enhance communication and resolve issues relating to that specialty.

The department chairperson or specialty consultant may also assist in the development of methodology for data collection and analysis and the interpretation of data regarding that specialty.

G. Disaffiliation

When making a decision to disaffiliate a physician, the most recent data available should be utilized and consideration given to such physician's response over time to data presented to him/her.

When disaffiliation occurs because of change in network size or composition, the disaffiliated physician should be provided with the reason, including the criteria and methodology utilized for disaffiliation decision.

When a physician chooses to disaffiliate, the physician should provide the HMO or physician group with the reason for such action.

White Paper on Physician Affiliation/Disaffiliation

(Continued)

IV. JOINT ACTIONS

CMS and the CHMOA will work collaboratively to undertake actions which will foster communication between physicians and HMOs and provide for non-adversarial dispute resolution.

A. Colorado Medical Society Physician Consultant HMO representatives will work with a physician "consultant" employed by CMS to develop "Physician Report Cards" and evaluate existing "Report Cards". Such consultant should have expertise in managed care and statistical analysis. Such "Report Cards" will consist of a set of criteria utilizing data whereby physician performance is evaluated. The "Report Card" development will include, but not be limited to, the following:

- (1) Review of data collection and interpretation methodology;
- (2) Review of data interpretation techniques to ensure that it is understandable and usable for guiding change in physician behavior; and
- (3) Identify issues that are based on data.

CMS and CHMOA will work towards identifying and developing data collection and analysis methodologies to be utilized in connection with affiliation/disaffiliation of physicians.

A physician consultant or other representative of CMS will be available to advise its member physicians regarding physician "Report Cards" and disaffiliation actions.

CMS and CHMOA will jointly establish a program to review and endorse data collection and interpretation methodologies established for evaluation of physicians.

B. Mediation Process

CMS and the CHMOA under the auspices of the Colorado Bar Association shall develop and jointly adopt a procedure for implementing a mediation program for physicians involved in the affiliation/disaffiliation process. Such procedure shall be voluntary on the part of each physician and each HMO or physician group and invoked only after exhaustion of any internal appeal process available to a physician.

CMS and the CHMOA will identify and arrange for training of a panel of mediators who will be available to participate in the mediation process.

CMS and the CHMOA will annually review the mediation process and jointly implement any needed changes to it.

CARDIOPULMONARY RESUSCITATION DIRECTIVES IN COLORADO



Doctor, are you really your patient's advocate?

Daily, the Colorado Medical Society (CMS) receives phone calls about CPR Directives. A recent article in *"Dear Abby"* (honest) spurred an increase in questions raised about where patients get these directives. As patients are looking for information about these directives, they make several phone calls before they reach CMS, at which time they are angry, frustrated, and sure that these forms don't really exist.

Patients should be getting information and CPR Directives from you, their physicians. Following is an update on how the State CPR Directive Program works:

State approved CPR Directive forms were developed to create a standardized form which would be easily identifiable, statewide, by emergency medical personnel and other health care providers. Patients do not have to use this particular form, but trainings are going on statewide regarding use and recognition of this particular form.

Forms are only available to patients through their health care providers (physicians, nursing homes, hospitals and other licensed or certified health care facilities). The purpose is to ensure a dialogue between the patient and health care provider regarding how a CPR Directive relates to the patient's individual health circumstances.

Physicians and other health care providers order the CPR Directives from CMS. (See order form on next page) The Directives are \$.50 each and come in two formats: 1) Patient Directives - for use by those persons who are capable of making their own decisions regarding CPR, and 2)

Authorized Agent forms - for use by an agent, chosen to make health care decisions for someone who lacks decisional capacity to make such decisions for themselves. This includes the parent or guardian of a minor child provided that a previous do not resuscitate order has been issued by a physician. (Verification of authorized agent status may be in the form of a proxy or reflected in a Medical Durable Power of Attorney.) Each form is available in both English and Spanish. With each form ordered, you will also receive an order form for a CPR bracelet or necklace. Each patient completing a CPR Directive, should also receive this order form. Patients desiring a CPR bracelet or necklace will send the pink copy of their Directive, along with this order form, to Award and Sign Connection, Ltd., the vendor making this jewelry.

The Directives are three-part forms. The **top copy is the original** and should be kept by the patient in a safe but easily observable place, or carried if no bracelet or necklace is worn. It is a good idea to advise the patient to inform family members of the CPR Directive and its location as well as to notify the local EMS provider agency of the Directive. The **second copy (yellow)** is to be kept by the physician in the patient's individual medical record. The **last copy (pink)** of the CPR Directive form is to be mailed by the patient with an order form for the necklace or bracelet.

A CPR Directive can be revoked only by the patient subject or by his or her authorized agent by destroying the original copy and the

"Dear Abby"®

necklace or bracelet (if purchased) or by stating that revocation is desired. The physician should be notified of this decision so that the yellow copy can be removed from the patient's medical record.

Patients sometimes get confused about the differences between Living Wills, Medical Durable Powers of Attorney and CPR Directives. A brochure entitled **Your Right To Make Health Care Decisions**, developed by the Advance Directives Coalition, is available through either the Colorado Hospital Association (303-758-1630) or CMS. Multiple copies can be ordered from Hospital Shared Services of Colorado (303-455-1420). If you have questions about the CPR Directives, please call CMS at 303-779-5455 or 1-800-654-5653 for information.

An order form for CPR Supplies and Information appears on the reverse of this page. **Have your staff copy it and use it!**

"Dear Abby"® is the property of the Rocky Mountain News and Abigail Van Buren, Los Angeles, CA.

Order Form for Supplies and Information Regarding Colorado Patient Directives

Ship to: _____

ATTN: _____

Address: _____

City/Zip: _____

Type of Facility: _____ Telephone () _____

Quantity	Description	Unit Price	TOTAL
	Ten Pack ENGLISH: Five Patient Directives Five Authorized Agent Directives	\$5.00	
	Ten Pack SPANISH: Five Patient Directives Five Authorized Agent Directives	\$5.00	
	Twenty-Five Pack ENGLISH: Patient Directives	\$12.50	
	Twenty-Five Pack SPANISH: Patient Directives	\$12.50	
	Twenty-Five Pack ENGLISH: Authorized Agent Directives	\$12.50	
	Twenty-Five Pack SPANISH: Authorized Agent Directives	\$12.50	
	CPR Directive Information Packet	\$3.50	
Add for postage:			
If order total is			
	Under \$25.00	add \$3.00	
	\$25.01 to \$50.00	add \$5.00	
	\$50.01 to \$100.00	add \$6.00	
	\$100.01 to \$200.00	add \$7.00	
	\$200.01 to \$300.00	add \$8.00	
	\$300.01 to \$400.00	add \$9.00	
	\$400.01 to \$500.00	add \$10.00	
TOTAL:			

CMS/6/95

- All orders must be prepaid before they will be shipped
- Allow 2 weeks for delivery
- Make checks payable to Colorado Medical Society
- Mail to: P. O. Box 17550, Denver, CO 80217-0550

Please copy this form and mail direct to CMS. Questions: Call 303-779-5455.

Physician's Financial Bulletin

Special Insert Number 8 for
Colorado Medicine, July, 1995

An exclusive member service of the Colorado Medical Society in collaboration with Chase Manhattan Investment Services, Inc.

THE EDITOR'S NOTES Who's Pushing the Market?

Recently, a recurring picture keeps creeping into my mind. I see two old mules pulling a creaking wagon labeled, "The Stock and bond Market" loaded to the brim with stock and bond certificates, climbing up a steep grassy knoll.

In the rear and pushing the wagon is Fed Chairman, Alan Greenspan dressed in overalls, a straw hat and perspiring heavily. As Greenspan approaches the crest of the hill, he reaches to wipe the sweat from his brow as his eyes focus on a large shade tree and a lone figure sitting under it. Clad in Bermuda shorts, leather sandals, a Hawaiian shirt, and chewing on a foot-long weed is President Bill Clinton. President Clinton waves and then shouts, "Keep that wagon moving Alan. . . your future and mine depend on it!"

Are We at the top?

If you are a contrarian, maybe the stock market has peaked! Consider this: According to the American Customer Satisfaction index (ACSI), which measures consumer perception of the quality of products and services, the only industry with a positive rating for the first quarter of 1995 was the postal services ... up 13.1%. Could this be the ultimate sell sign ?

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NEXT ISSUE:

Estate Planning

Being sure you have one to plan

Medical Practice Management

Buying vs Leasing

Retirement Wisdom

Physicians can do it wisely.

The Bulletin Board

Required reading:

"Of Permanent Value"
The Warren Buffett Story.

Here's a quote:

"The most important quality for an investor is temperament, not intellect. You don't need tons of IQ in this business. You don't have to be able to play three-dimensional chess or bridge. You need a temperament that neither derives great pleasure from being with the crowd or against the crowd. You know you're right, not because of the position of others, but because your facts and reasoning are right."

Investment advisory and securities services are provided by Chase Manhattan Investment Services, Inc., (CMIS), a member of The Chase Manhattan Bank, N.A. CMIS is a member of the NASD and SIPC.

Securities involve investment risk, including the possible loss of principal. They are not FDIC insured bank deposits and are not guaranteed by, or obligations of, The Chase Manhattan Bank, N.A. or CMIS.

Survey Update

As of June 1, 1995, 8.9% of the CMS membership had responded to the 1995 Financial Survey.

Here are a few responses to the question, "What is your biggest financial concern?"

- retirement, loss of income, managed care
- taxes
- collecting my P.C. receivables
- children's education
- someone suing me and taking my assets
- collapse of U.S. economy
- the future of medicine

We appreciate all responses. Watch for a complete survey update from Bill Pierson (*Colorado Medicine*) in the near future.

Educational Workshops

The Surveys indicated "Change Needed"!

The "Physician's Seminar Series" over the past 3 years has presented educational topics and introduced guest speakers with varied financial expertise. The polled results from the recent Physician's Survey show an active interest in the seminar series, but the noon time period at the Colorado Medical Society made it difficult for many to attend.

We will arrange the new series to be held in the evenings (5:30 - 7:00 PM) and on Saturday mornings from 8:30 AM - 10 AM. The sessions will be centrally located at Chase Manhattan Headquarters on I-25 and Colorado Blvd.

Introducing the new

1-800 Market Insight Conference Call

An important addition to this year's workshops will be the introduction of the Market Insight Conference Call. Be watching in this section of the financial report for the 1-800 number to call in on to listen and participate on a conference call with the nation's leading mutual fund managers, private money managers, noted economists from Chase Manhattan and other financial institutions who will discuss timely topics related to changing market conditions. This program is made available for physicians in and out of the major metro areas, to conveniently participate from your home or office

Noted Author to present

"Taxes, Lawsuits and Family Conflict"

Our presenter, Richard W. Duff's most recent book "Preserving Family Wealth" sells nationally and is a highly regarded publication among estate planning attorneys. Mr. Duff is past president of the Denver Estate Planning Council and is a member of the Colorado and Denver Bar Associations. This session will be held **5:30 - 7 PM on Thursday, August 17** at the Chase Conference Board Room on the 12th floor of the Colorado Center Tower Building, 2000 S. Colorado Blvd., Denver, CO 80222.

Call today to make your reservations (303) 782-8008, or return the attached self addressed postcard.

From a Woman's Perspective

Judi Lundquist and Diane Weisert

Women are different from men. Before you turn cynical, mutter "No kidding" and discard this newsletter, let us clarify where we're headed with this. The physical, emotional and other perceived differences (or similarities) between men and women have been and will probably continue to be debated into infinity. What we're concerned with in this column are the financial planning needs that women have. And quite often these are very different from men's.

Although investment and financial planning are difficult tasks for everyone, they can often be more daunting for women. Consider the following statistics cited by the National Center for Women & Retirement Research:

- **Women live longer than men.** (Again, no kidding!) But surprisingly, the average age of widowhood is 56!
- **80% of women are left in financial jeopardy through widowhood or divorce.**

- Although the assumption here would be that this only applies to lower income women, the effects of either one of these events can be devastating at any financial level.
- **50% of working women do not have current pension programs.** Admittedly, most professional women do participate in some type of retirement plan, but we've also met more than a few who don't have any type of retirement savings set up.

The reality in these statistics is that women do face some challenges in planning their financial futures and in all likelihood may be doing so alone. So what words of wisdom can we offer?

Here are a couple steps every women should take

Have a plan. Whether single or married, you need to sit down and write out your short- and long-term financial goals. If your spouse has already done this (with or without your input), make sure you know what the plan is and agree with its goals.

Lay out a strategy. Without a strategy for achieving your goals, you're just pipe-dreaming and thinking wishfully. Again, put it in writing.

Take or share responsibility for decisions. Get involved in determining what your future will be. We all worry about making wrong decisions or bad choices, worse still is to make no decisions.

In future columns, we'll talk about each of these steps in more depth. In the meantime, it probably wouldn't hurt any of us to remember one very small footnote from history..... before "***In God We Trust***" was put on U.S. coins, the slogan that was used was "***Mind your business***". It might have been used in a different context then, but when it comes to money today, it's worth recalling.

From the Money Manager's Corner*

"The Wall of Worry"

At the present time we feel that there continues to be a "wall of worry" among investors that possibly represents the most stabilizing force to U.S. financial markets for the remainder of 1995.

The major concern appears to be the continuing deterioration in the value of the dollar. We believe that there are significant reasons to expect improvement on the dollar.

Federal Reserve policy has been tight, to the extent the U.S. interest rates are competitive with the rates of our trading partners. Japan cannot effectively compete with U.S. products and will attempt to reduce negative currency impacts by investing in expanding facilities in this country. U.S. goods producers are the most competitive companies in the world today. As a result, we expect improving exports, especially to Europe and Japan as these countries demonstrate stronger economic growth than the United States. We must stress, however, that this will not be a permanent, long-term improvement, unless the U.S. savings rate advances dramatically and our Federal Government takes significant action that has immediate impact upon improving our budget deficit.

A close examination of the key economic components does, however, reinforce our very positive long-term outlook for U.S. stocks and bonds.

- We expect a short term positive resolution to the weakness in the dollar
- We continue to expect a relatively low rate of inflation during 1995
- Slower economic growth for the remainder of 1995 and extending into 1996
- We expect interest rates to stabilize and trend lower as we move through 1995 corporate earning should continue to demonstrate steady improvement.

*The "Money Manager's Corner" article was supplied by:

Capital Investment Counsel Inc.
101 University Boulevard, Suite
400, Denver, CO 80206-4632.
Telephone - (303) 329-9000
FAX- (303) 329-9666

Market Data

Indicator	12/31/94	2/7/95	6/22/95
Prime Rate	8.50	9.00	9.00
6 month T-bill	5.88	6.35	5.42
30 yr. T-bond	7.50	7.51	6.47
DJIA	3834.44	3937.30	4589.64
S&P 500	459.27	480.81	551.07

Mortgages-New Purchases

No discount fee - No obligation fee

	12/31/94	2/7/95	6/22/95
30 year fixed	10.0%	9.59%	8.26%
7 year fixed	9.375%	9.00%	7.458%
5 year fixed	9.125%	8.50%	7.208

These rates are subject to change without notice.
Chase Manhattan is an

Equal Housing Opportunity Lender.



Jack, please contact me regarding (please circle topics):

Home Mortgages

Equity Line of Credit

Education Debt Refinancing

Tax Planning Strategies

Retirement Plans

Financial Planning

Estae Planning

Trust Services

Portfolio Analysis/Investments

Auto Financing

☐ I would like to attend **"Taxes, Lawsuits and Family Conflict"** at 5:30 pm on Thursday, August 17, 1995.

There will be _____ people in my party.

Name _____

Address _____

Phone (H) _____

(W) _____

Best time to contact: _____

From Concept to Reality

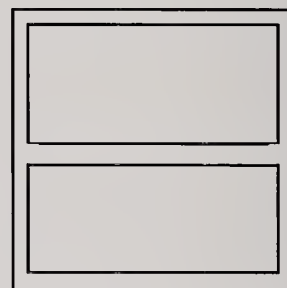
. . . . Building a Custom Home

by
James E. Donahue
President, American West Homes*

You've heard the horror stories from friends and colleagues that building their home was the worst experience of their life. It doesn't have to end up that way if, as in any business venture, you plan and perform due diligence. When I was asked to write this article, I took a hard look at us and our clients. The common factor I found was compatibility! To me, this is the foundation of a successful deal. Building a home is extremely personal. Make sure you can share that with your builder!

Keep the following points in mind when searching for a builder to take your home from concept to reality:

- Know what you can afford and then subtract 15%. This will allow you a margin for cost overruns, upgrades and landscaping later in the building process.
- Have the builder prepare a detailed cost estimate and specification sheet. Review these carefully, make notes and ask questions!
- Have allowances for carpet, tile, plumbing fixtures, lighting and other miscellaneous custom items that you don't have costs nailed down on.
- Have your builder take you through 1 or 2 homes they have completed recently.
- Check references from past clients, trade organizations, etc.
- If purchasing a lot from the builder, get a copy of the soils report and title insurance.
- Start now on your permanent financing. Know up front what the money is going to cost you.



When you are satisfied with all the above, have the builder prepare a draft of the contract. Make sure there are provisions for change orders (i.e., the cost of any extra work will be actual cost plus X percent). Also, time frames, lien waivers, insurance and a binding arbitration clause will save time and money for both you and the builder if a problem arises. Make sure to get a copy of the warranty; it's best to know now what to expect later. Remember that the deal becomes a negotiation at the contract stage.

Know where you stand, get it in writing and always have your attorney review it before signing! There are many other situations that will come up, but if you go into the process with your eyes open, it will be fun, challenging and extremely rewarding. Good Luck!

*American West Homes is a Colorado Corporation, established in 1988, and builds custom and semi-custom homes throughout the Denver metro area. American West is affiliated with Home Builders Association, Builder Realty Council, and Public Service Company's "Ideal Energy" Program.



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Physician's Financial Bulletin

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PF Bulletin

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C M S



CHAS





*Richard Allen, MD
Chairman, CMS Council on Legislation*

"We need to have physicians in every district who have a good relationship with their legislators. . ."

Last month I wrote an article reflecting on the just-adjourned State Legislature. It was a session concluded with many more pluses than minuses for us, but was also a learning experience giving us some guidance for the year ahead. Thus I wrote in the 120-day letter, "This does not mean that we are finished, because now the planning begins for next year". The natural tendency is to kick back and enjoy the summer (assuming we have some good weather), and not worry about legislative concerns until the fall. That is absolutely what we cannot do; therefore, we have already started with a series of planning sessions and meetings that will continue throughout the summer.

Since the legislature adjourned, the CMS leadership has had one legislative planning meeting to set goals and priorities. The Government Relations staff and I had a

meeting with the pharmacists who are looking for support of a bill to broaden their authority to include prescription writing and "collaborative practices". We have also taken steps to block a move by naturopaths to expand their scope of practice. The Rural Health Task Force has continued to meet, setting a timetable for producing a legislative bill, and they have set an ambitious goal of having a bill drafted by July 1 to send to the legislature and solicit comments.

One of the most important initial meetings was with key members of the Business Coalition to see if we could find some agreeable common ground regarding patients' access to their physicians for health care. As you recall, the Business Coalition strongly opposed our Point-Of-Service bill in the last legislature and we feel we must have them on our side if we are to have any success. Therefore, they have to understand where we are coming from and that, far from being anti-business, the measures we are suggesting are pro-business. Drs. Karlin and Martz, Sandi Maloney and I, met with five important members of the Business Coalition. It was a very pleasant and agreeable meeting. We all felt we have much more in common than not, and that we would be logical allies. Everyone agreed to pursue these talks over the summer and we have dates set for future meetings. I think we all came away from this initial meeting strongly encouraged that we can probably get a patient choice/access bill before the next legislature.

Another area that we need to start working on is building up a key contact list. Key contacts are extremely important in passing legislation. We need to have physicians in every district who have a good relationship with their legislators and can approach them on issues of importance to health care and the patient's welfare.

It is extremely easy to be a Key Contact and this is an area where every one of you can have some influence. Toward that end we also held some meetings with COMPAC and started planning for the Colorado Medical Society Annual Meeting in September where we hope to further increase our COMPAC membership. The stronger COMPAC is, the stronger our lobbying efforts will be, and that takes both members and money.

Lastly, our AMA Delegation will have been in Chicago for the AMA Annual Meeting where, in a national forum, we were planning our activities. We have been extremely fortunate in having our president elect, Joel Karlin, M.D., appointed to the Council on Legislation for the AMA.

So you can see we are not taking the summer off. There is lots going on and plenty to do. Those of you who want to get involved and be part of our key contact list, please call the Government Relations Department at CMS. We welcome any and all support and participation.



HEALTH CARE FINANCING

Medicare Evaluation and Management Seminars

by Grant E. Steffen, MD
Medical Director, Medicare "B"
Colorado/Wyoming
Blue Cross/Blue Shield of North Dakota

The new documentation guidelines

On January 11, 1995, Dee Cole, Dennis Delpizzo, and I gave our first Evaluation and Management (E/M) seminar at the Aurora Presbyterian Hospital. We gave our 45th (and, presumably, final) seminar at Cañon City on May 3. In between those dates, we visited fourteen other metro-Denver hospitals plus the communities of Longmont, Greeley, Fort Collins, and Fort Morgan in the northeast, Limon, Lamar, La Junta, Pueblo, and Colorado Springs in the southeast, Steamboat Springs, Craig, Glenwood Springs, Grand Junction, and Montrose in the northwest, and Alamosa, Durango, and Cortez in the southwest. Personal observation - it's a wonderful state!

A great part of the huge task of scheduling all these seminars was managed by Edie Register at CMS and many of the county society staff members. I want to personally thank all those people who helped us with this task and for frequently furnishing breakfast, lunch, or dinner. I would also like to thank all the physicians and staff who attended the seminars, and particularly those who asked the pertinent questions and offered valuable recommendations.

I would like to emphasize several points which concern general documentation principles and which generated a lot of discussion. First is the need to justify the requirement for adequate documentation. There are some physicians who maintain the position that their particular brand of shorthand is quite adequate for their clinical records. This position is probably sufficient for their personal needs, but may not

be for their colleagues who, in their absence, may have to take care of their patients. This is the basic and sufficient reason for good documentation, the clinical record that allows continuity of care.

A second reason is the need of a reviewer to have an accurate and complete record. The reviewer may have to determine that the physician billed the correct code, that the patient had appropriately accessed the system, or for epidemiologic reasons that a particular disease state existed. So there are, I believe, many good non-clinical reasons that justify the requirement for good documentation.

A third reason is the legal requirement. I believe that the average physician is more likely to have to defend his or her medical record in court or in front of a committee of the liability insurance carrier than in front of a Medicare reviewer. Of course, if the physician has a billing pattern that is far from the average, that fact will increase the chances of a Medicare review. At any rate, these legal requirements surely create a prudent if not a clinical motivation for good documentation.

Some physicians believe that the severity of the patient's illness automatically justifies a high-level code. This is not the case. The patient may be very ill, but the diagnosis is known and the treatment options are limited. In this case, the physician's E/M service may be modest even though the patient is quite ill. Of course, the

(Continued)

Medicare Evaluation and Management Seminars: The new documentation guidelines

(Continued from preceding page)

patient's presenting problem will generate a particular level of history, examination, and decision making. These will, in turn, generate a clinical record, and it is that record that must justify the E/M code billed. The patient's presenting problem will therefore, indirectly determine the code billed. The intervening steps, the service itself and its documentation, tie the presenting problem to the code that one bills. These comments refer, of course, to the second reason for good documentation, the chart review by a third party payer. Ordinarily, the code billed is neither a clinical nor a legal issue. But this is the particular reason that the AMA and HCFA have developed the Documentation Guidelines that the seminars presented, to help the physician to make the transition from the record to the code billed.

Another issue that generated a lot of discussion was my distinction between the clinical record and the claim form. Each has its own documentation requirements. In particular, the claim form needs only one, and will accept only one diagnosis per line item billed. Some physicians believe that they need to justify, on the claim form, a high level code, e.g. 99215, with more than one diagnosis. This is not the case. In general, any medical condition will allow payment for an E/M service billed. This is, of course, not true for procedures or for drugs given incident to the visit. In these cases, there is often a narrow range of diagnostic codes that will allow payment.

The new documentation guidelines are presented with the specific aim to help the physician to better understand the makeup of the various evaluation and management or visit codes that are available. Consider the task of defining these

codes. The AMA has, in its CPT manual, defined many diagnostic and therapeutic procedures, and these definitions can generally be logically constructed since most procedures have fairly well defined components. In contrast, the visit between the physician and the patient is infinitely variable and extraordinarily complex. Still, it is necessary to assign different levels to these visits since they do vary in intensity and compensation should reflect these levels. The evaluation and management codes that came out in January, 1992 are the AMA's most recent definitions of these levels, and these new documentation guidelines are the AMA and HCFA's latest refinements of these definitions.

I would like to emphasize several specific points that concern these new guidelines. All four levels of the history require either a brief or an extended history of the present illness. However, many office visits are for purposes of follow-up for an acute illness or monitoring a chronic illness. In either case, there may be no presenting complaint, since the patient is asymptomatic. The present illness is, therefore, "negative". A brief comment about the continued resolution of the presenting or chronic symptoms would be appropriate.

Concerning the exam, I pointed out that we still have no definitions for a limited, extended, or complete examination of a single organ system. We have a definition for a general multisystem exam, namely an examination of eight or more of the systems. This is the examination required for a "comprehensive" exam. If anyone has recommendations for defining the various levels of a single organ exam, I would be very happy to get them.

The third element that determines the code that one bills is the complexity of the decision-making process. One part of this element is the risk to the patient of the disease, so here the patient's condition does directly affect the code billed. In general, a clear statement of your impression, including ruled out

diagnoses and your plan including tests ordered or reviewed, will satisfy the guidelines.

This carrier will, during the next three months, ask a few randomly selected physicians to send in records of a recently billed E/M code. We will review the record to see if the correct code was used, and will tell the physician if the level billed was too low, correct, or too high. This is strictly an educational review. The carrier may use the new documentation guidelines for E/M services billed after July 31, 1995 and so will probably not use them until late 1995 or 1996.

I believe that the standards created by these guidelines are modest and that the guidelines should help the physician to select the correct code for the services documented. Finally, I hope that the physicians accept these guidelines in the spirit in which they are offered, to help better understand the E/M codes and to bill those codes correctly.

Medicare Evaluation & Management Documentation Guideline Video Tape Available

If you were unable to attend one of the E & M Workshops, a VHS video tape is available. This is an edited version of the original presentation given to the Medicare Medical Directors in September, 1994.

The tape is approximately 90 minutes long. **Please Note:** these documentation guidelines were specifically for the physicians/practitioners who write or dictate the various portions of the E & M codes.

There is no charge for use of the tape, but the Medicare office requests you return the tape within two working days of receipt. To place your name on the list for borrowing the tape, (first come-first served), call Provider Service at (303) 831-1221.



LETTERS

Note: The letter at right was written by CMS member Dr. Steven Gulevich in response to the article below.

NETWORK NEWS

A Publication for Blue Cross and Blue Shield of Colorado providers Vol. 3, No. 1, First Quarter 1995

Proposed legislation threatens managed care

What would you think if nurses who had the minimum requirements could demand that a hospital hire them? Or what about a technician who's just graduated from the local trade school insisting that a lab employ him?

Crazy? We think so. But if "any willing provider" legislation passes, we'd have to do just that - accept any provider who wants to join our network as long as he or she agrees to our minimum requirements. We think any willing provider legislation would hurt the quality of patient care. It would take away our ability to choose providers based on quality of care, customer service and scope of medical services. We're also concerned that any willing provider legislation would increase health-care costs. If we have to accept all providers, we couldn't guarantee patient volume in exchange for discounted fees. Consequently, health-care costs would go up.

Perhaps more importantly, we're convinced that managed care is the solution to controlling health-care costs while providing medically sound, high-quality care. In fact, studies show that managed-care patients have the highest overall satisfaction with their health plan.

According to a survey of 10,000 health-plan participants nationwide, 63.3% said they were very satisfied with their HMO plan. This compares to 55.1% who were very satisfied with their indemnity plan. Patients and physicians alike also note that they appreciate the wellness and preventative-care aspects of managed-care programs.

More than one million Coloradans are members of a managed-care plan. The growing popularity of managed care is proof that the marketplace accepts and understands the benefits of managed care over traditional, indemnity products. Because any willing provider legislation contradicts this, we don't see it as a solution to health-care reform. After all, would you want to be forced to hire every person who has the minimum requirements?



Dear editor,

I am writing in reply to "Proposed legislation threatens managed care", which appeared in *Provider Network News*, volume 3, no. 1.

Any willing provider legislation poses no significant threat to managed care programs with regard to quality. With proposed legislation, insurance companies could continue to set standards to assure experience, board certification, or whatever necessary to assure that all panel doctors are highly qualified to provide quality care for patients.

Larger panels will encourage healthy competition among doctors with the system to optimize what patients care about: availability of treatments, attentiveness to the patient's questions and concerns, and friendliness of office staff. Physicians will remain motivated to provide the highest quality of care

possible knowing patients have a choice of doctors, a motivation which is absent when doctors are guaranteed patients by inclusion in a restricted panel.

Any willing provider legislation is intended to prevent trained and qualified doctors from being denied access to patients. It will not hinder insurance companies' efforts to end over utilization, the most significant cause of health-care cost inflation. Of course, it would make it more difficult for insurance plans to reduce individual physicians' fees because they will have more physicians to deal with. But having more doctors benefits patients by giving them greater choice, and ultimately probably benefits insurance plans as well, by making them more saleable and by keeping patients happy.

Sincerely yours,

Steven J. Gulevich, M.D.

Dear Colorado Medical Society,

I am writing to pay tribute to Dr. John Gottlieb of the Vail - Summit Orthopedics and Sports Clinic at 181 West Meadow Drive, Vail, CO. The medical treatment we received deserves recognition.

During a recent skiing holiday in the US, my wife, Leslie, had the misfortune to suffer a serious knee injury which necessitated surgery to replace her ACL ligament. This was carried out with great speed and expertise by Dr. Gottlieb. Less routine, however, was the way in which - realizing that my wife and I were stranded far from home - he insisted we stay with he and his family while Leslie made her recovery. He and his family couldn't have been more kind to us! They were very welcoming and their hospitality got her recuperation off to the best possible start.

You are very fortunate to have within your parish someone like John Gottlieb. Not only are his medical skills considered some of the best in the nation, he is the most generous and kind person. Truly, a credit to his profession.

Yours sincerely,

Mark Canning
First Secretary (Commercial)
British Embassy
Jalan M.H. Thamrin 75
Jakarta 10310
Indonesia



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Rehab News

NovaCare Offers New Rehab Program for Post Breast Surgery Patients

It's a well known fact that the leading cause of death for women age 35 to 54 is breast cancer. Last year, there were more than 182,000 new cases of breast cancer in the United States with 1900 of them occurring in Colorado. Despite much publicity regarding the prevention and treatment of breast cancer, little attention has been given to complications which may develop after surgery. Potential complications after breast surgery include pain, shoulder dysfunction, difficulty performing normal daily activities, lymphedema and emotional distress.

NovaCare Outpatient Rehabilitation, the nation's leading provider of outpatient physical therapy services, developed a new program designed to help women return to normal function and well-being after breast surgery. Studies have shown that physical therapy treatment after surgical intervention, whether it be a lumpectomy or mastectomy, can help facilitate a woman's recovery from breast surgery. The program "Physical Therapy after Breast Surgery" was developed by Felicia Krieger, PT, ATC, at NovaCare's Southeast center in Denver.

"This program really benefits women by safely and quickly rehabilitating physical limitations, as well as educating women on the prevention of future complications," said Krieger. "We accomplish this through various stretching and strengthening exercises as well as Manual Lymphatic Drainage to help improve function with daily living activities. Prior to completion of the program, patients receive education and instruction on a home exercise program to help them continue their rehabilitation confidently on their own."

The program has been well received in the Denver market and is being rolled out in other NovaCare markets across the country. Physician referral is necessary in most cases. "If a woman finds she is having limitations physically or emotionally after surgery, she needs to communicate that with her physician," concluded Krieger.

For more information about the program, contact Felicia Krieger at (303) 759-1063.

NovaCare Outpatient Rehabilitation is a division NovaCare, Inc., the leading rehabilitation management services company in the United States.



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"Who's On First?"



Sandra L. Maloney
Executive Director
Colorado Medical Society

Abbott and Costello, though not CMS members, accurately described the current state of the business of medicine. Just when you think you've got it figured out, someone changes the rules... again. We've structured the activities at this year's Annual Meeting to be your program and scorecard for the '90s and beyond. Find out who the players are in our 1995 Educational Program, "Who's On First?"

Everything the CMS staff, Councils, Committees and Task Forces do is determined by resolutions presented at the meetings of the House of Delegates. Not only that, but each member has an equal opportunity to present resolutions for consideration, to testify before a Reference Committee (or even serve on one) and to have a dramatic impact on the direction CMS will take on important issues in the coming year. The Colorado Medical Society really *is* a member driven organization.

We have lots of educational and fun activities scheduled for you this year, in addition to the business meetings that set CMS policy and drive all our activities for the year.

Look over the enclosed information, select those activities and meetings in which you would like to participate and fill in your registration form. You then may mail it to us (at PO Box 17550, Denver, CO 80217-0550), phone it to us (at 303/779-5455) or even FAX it to us (at 303/771-8657).

Get your registration in quickly. There are limited spaces available for some programs. Notice also that you will need tickets for all meal functions. We must remain fiscally responsible by getting an accurate count of those who will attend these functions.

I encourage you to put on your baseball duds for the reception on Thursday and join us for "Puttin' on the Ritz" at the President's Dinner Dance on Saturday. I look forward to seeing you in Aspen!

Sandra L. Maloney

COLORADO MEDICAL SOCIETY AND COLORADO MEDICAL SOCIETY ALLIANCE

Tentative 1995 Annual Meeting Line Up

Ritz Carlton Aspen
September 7-10, 1995

THURSDAY, SEPT. 7

8:00 am ---	CMS Office open
12:48 pm ---	18 hole Golf Tournament
4:30 pm --- 8:00 pm	Registration open
6:00 pm --- 7:30 pm	"Batter Up" Reception
7:30 pm ---	Dinner on your own
NOTE: Dress for Annual Meeting	
Thursday evening	
reception:	baseball attire or casual
Friday:	casual
Saturday morning:	casual
Saturday inaugural	
dinner/dance:	black tie preferred
Sunday:	casual

FRIDAY, SEPT. 8

7:00 am ---	CMS Office opens
7:00 am --- 5:00 pm	Registration
7:00 am --- 8:30 am	El Paso County Caucus
7:15 am --- 8:15 am	Reference Committee Breakfast
8:00 am --- 12:00 N	Exhibits open
8:15 am --- 8:45 am	Credentials Committee
8:30 am --- 9:30 am	Alliance Board Breakfast
8:45 am --- 9:15 am	Opening Session House of Delegates
9:15 am --- 11:45 am	General Membership Meeting
9:45 am --- 11:45 am	Alliance General Meeting
9:45 am --- 10:15 am	Coffee break
12:15 pm --- 1:45 pm	COMPAC/CMSA Luncheon
2:00 pm --- 4:30 pm	Reference Committee*
2:00 pm --- 3:00 pm	Alliance Workshop
2:00 pm --- 5:00 pm	Army National Guard Physicians
2:15 pm --- 3:15 pm	Copic Risk Management
2:15 pm --- 3:15 pm	Copic Risk Management
3:00 pm --- 5:30 pm	Reference Committee*
3:00 pm --- 4:30 pm	Alliance County Breakout Sessions
3:45 pm --- 4:45 pm	Copic Risk Management
3:45 pm --- 4:45 pm	Copic Risk Management
4:00 pm --- 6:30 pm	Reference Committee*
4:00 pm --- 7:00 pm	Exhibits open
5:30 pm --- 7:00 pm	Exhibitor Reception
6:30 pm --- 7:30 pm	Colorado Society of Internal Medicine Annual Meeting
7:00 pm --- 9:00 pm	Gone But Not Forgotten Dinner

*Number and starting times of Reference Committees subject to change depending on number of resolutions submitted

SATURDAY, SEPT. 9

7:00 am ---	CMS Office opens
7:00 am --- 11:00 am	Registration
7:00 am --- 7:50 am	Educational Program Continental Breakfast
7:00 am --- 11:00 am	Exhibits open
8:00 am --- 12:00 N	Educational Program "Who's on First? or What Opportunities Will You Have to Practice Medicine in the Future?"
8:00 am --- 12:00 N	Alliance Meeting - "Unplug the Holiday Machine"
12:00 N ---	Recreation Time golf, tennis, horseback riding, biking, fishing, walking, etc.
12:30 pm --- 2:00 pm	Women in Medicine Meeting @ the Center for Environmental Studies
2:00 pm --- 3:00 pm	WIM tour @ the Center for Environmental Studies (open to all)
1:00 pm --- 4:00 pm	Copic Workshop-Physician Integration Phase II & Beyond
1:00 pm --- 4:00 pm	Army National Guard Physicians
1:30 pm --- 3:00 pm	Unified Grievance Committee
6:00 pm --- 6:30 pm	Inaugural Address
6:30 pm --- 7:00 pm	Cocktails cash bar
7:00 pm --- 10:30 pm	Presidents' Dinner/Dance
9:30 pm --- 11:00 pm	Copic Dessert Reception

SUNDAY, SEPT. 10

6:30 am ---	Reference Committee Reports available
7:00 am ---	CMS Office opens
7:00 am --- 10:00 am	Registration
7:00 am --- 8:30 am	Component Caucuses
	Arapahoe
	AuroraAdams
	Boulder
	Clear Creek Valley
	Denver
	El Paso
	Larimer/Weld
	Pueblo/Western Slope
8:00 am --- 8:30 a.m.	Credentials Committee
8:30 am --- 12:00 N	Closing Session HOD
9:00 am --- 10:00 am	CMSA Gavel Club Breakfast
12:00 N --- or immediately following HOD	Nominating Committee
12:00 N --- or immediately following HOD	Reorganizational Board

Tentative Annual Meeting Registration

1995 Annual Meeting of the Colorado Medical Society and CMS Alliance
 September 7-10, 1995, Ritz-Carlton, Aspen, Colorado

Name (please print) _____

Name of Spouse/Guest(s) (if attending) _____

Component Society _____ Office Phone _____

If you are not a member of CMS, please provide the following:

Company/Organization _____ Title _____

Reservations for Events and Meetings

Reservation deadline is August 25, 1995. (Note: To attend the President's Dinner Dance on Saturday, you **must** obtain your tickets before noon, Friday, Sept. 8.) Reservations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders.

As a member, **you and one guest are entitled to attend the complimentary events at no charge.** Please indicate the number of additional guests at the bottom of this form and enclose your check.

Complimentary events open to all members:

THURSDAY, SEPTEMBER 7

6:00 pm Reception: Batter Up! member ☐ guest ☐

FRIDAY, SEPTEMBER 8

5:30 pm Exhibitor Reception member ☐ guest ☐

SATURDAY, SEPTEMBER 9

7:00 am Educational Program Continental Breakfast member ☐ guest ☐

8:00 am Educational Program: Who's on First? member ☐ guest ☐

4:30 pm CMS Alliance Reception member ☐ guest ☐

(for Alliance members & interested spouses)

7:00 pm President's Dinner Dance: **Putting on the Ritz** (Black tie preferred)

(Reservations necessary, please select menu below)

Beef Dinner, or member ☐ guest ☐

Chicken Dinner member ☐ guest ☐

9:30 pm Copic Dessert Reception member ☐ guest ☐

Additional Reservations (other than member + 1 guest):

Reception: Batter Up! # _____ @\$10 each= _____

Educational Program Breakfast # _____ @\$15 each= _____

President's Dinner Dance (Reservations necessary, please select menu below)

Beef Dinner, or # _____ @\$50 each= _____

Chicken Dinner # _____ @\$50 each= _____

..... Total for Additional Reservations \$ _____

Non-Complimentary Events:

Cost

Number

FRIDAY, SEPTEMBER 8

8:30 am CMSA BOD Breakfast \$30 each _____

12 Noon COMPAC/CMSA Luncheon \$25 each _____

SATURDAY, SEPTEMBER 9

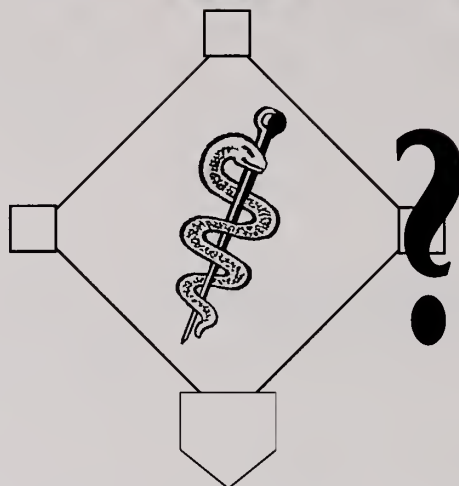
12 Noon Women in Medicine Lunch/Business meeting \$15 each _____

..... Total for Non-Complimentary Reservations \$ _____

Total enclosed for non-complimentary and/or additional reservations \$ _____

After completing this form, please mail it to us (at PO Box 17550, Denver, CO 80217-0550), phone it to us (at 303/779-5455 or 1-800/654-5653) or FAX it to us (at 303/771-8657).

WHO'S ON FIRST?



Colorado Medical Society Annual Meeting Educational Program

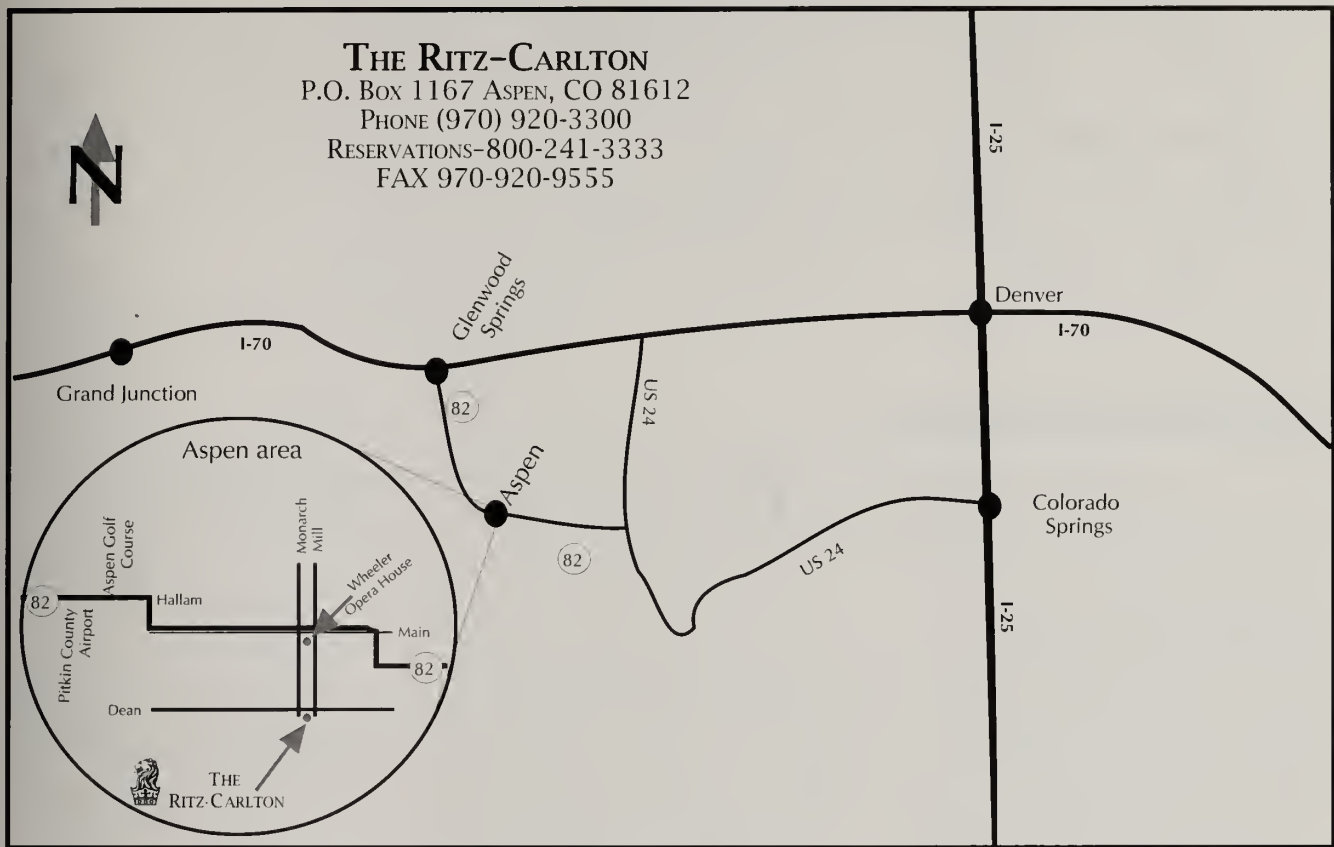
Saturday, September 9, 1995

Ritz Carlton, Aspen

Who's on First?

(or What Opportunities Will You Have to Practice Medicine in the Future?)

- | | |
|---------------------|--|
| 8:00 am - 8:10 am | Welcome and Introduction— Joel M. Karlin, MD, CMS |
| 8:10 am - 8:25 am | Overview— Joe Aita, MD, Lifeguard |
| - | Presentations: |
| 8:25 am - 8:45 am | Dick Wright, PhyCor |
| 8:45 am - 9:05 am | David Vandewater, Columbia/HCA |
| 9:05 am - 9:25 am | Mark Donahue, PruCare |
| 9:25 am - 9:45 am | Toby Cole, MD, Kaiser Permanente |
| 9:45 am - 10:05 am | David Ginsberg, Healthcare Consulting |
| 10:05 am - 10:25 am | Break |
| 10:25 am - 10:55 am | Breakout groups headed by each of the presenters so attendees can ask questions in small group setting |
| 10:55 am - 11:25 am | Panel discussion moderated by Dr. Aita—panelists to highlight questions/information from breakouts |
| 11:25 am - 11:55 am | Q&A |
| 11:55 am - 12:00 N | Concluding remarks— Joel M. Karlin, MD |



**Colorado Medical Society
Annual Meeting
September 7-10, 1995**



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Name _____
Address _____
City _____ State _____ Zip Code _____
Phone Number _____ No of Guests _____
Arrival Date _____ at _____ (Check in time is 3:00 pm)
Departure date _____ at _____ (Check out time is 12:00 noon)

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☐ Diners Club

☐ MasterCard
☐ Carte Blanche

☐ Visa
☐ Check enclosed

Account Number _____ Expiration date _____
Credit cards will be charged at the time the reservation is made.

Signature of Card Holder _____

Deposit: Each reservation must be accompanied by a two-night deposit which will be applied to the first and last night's stay. Deposits are to be received no later than August 18.
Deposits are refundable if reservations are canceled more than 7 days prior to arrival. All deposit money is non-refundable if a cancellation is made within 7 days of the arrival date.
Reservation Cutoff: Rooms will be held for the attendees of Colorado Medical Society at this special rate until August 18. Reservations received after this date will be accepted on a space available basis at the group rate.

Special requests _____

CMS Annual Meeting Golf Tournament

at Aspen Golf Course
Thursday, September 7, 1995
Entry Form

Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____ Home Phone _____ FAX# _____

(Needed for tee times)

While in Aspen I will be staying at _____

I will be attending the meeting in the capacity of (check one)

☐ Physician

☐ Exhibitor

☐ Spouse

☐ Other

I will:

☐ Sponsor a golf course hole @\$100

☐ Sponsor a putting green contest hole @\$50

Name of sponsor (as you wish it to appear on sign) _____

(Professionally made signs will be displayed for sponsors.)

My golf handicap is _____

☐ USGA

☐ Other

I will require rental clubs @ \$60

☐ Left handed

☐ Right handed

(Big Berthas may be available)

Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference of who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament entry, registration form and advance payment of \$100 must be received **no later than** August 21, 1995. Cancellations received after August 21, 1995 are refundable subject to ability of Aspen Golf Club to "resell" vacated tee times.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at 970-925-2145.

I prefer to be teamed with _____

* Mail Entry Form and check to Media Specialties, P. O. Box 36357, Denver, CO 80236. For additional information, call Tim Jackson at 303-986-5926.

Joseph Aita, MD to Keynote Annual Meeting



S. Joseph Aita, MD, Executive Vice President and Medical Director of Lifeguard, Inc. will be the keynote speaker at the 125th Annual Meeting of the Colorado Medical Society, September 9, 1995 in Aspen, Colorado. Dr. Aita has long been known for his leadership in managed care, outcomes research and practice guidelines.

The title for the keynote address will be "What is Value....And How Is It Measured?". Dr. Aita's remarks will center around the perception of value by the multiple constituencies involved in health care delivery and especially focus on how physicians can improve the objective assessment of their own value in health care delivery.

Look for more details on this presentation, as well as the 1995 Educational Program, "Who's On First?" in the August issue of *Colorado Medicine*.

Rules and Regulations Recently Passed by the Board of Health

The Colorado Medical Society's **HEALTH AFFAIRS COUNCIL** discussed and agreed to support the following rules and regulations which subsequently were adopted by the Board of Health.

Methods of Investigating Epidemic and Communicable Diseases

The Board of Health recently expanded the methods of investigation for epidemic and communicable diseases to include: medical examination and testing of persons, with their explicit consent; obtaining from public or private businesses lists of persons, travelers, passengers or transportation crews who have had a similar exposure to a reported case; collecting environmental specimens; taking photographs related to the purpose of the investigation; surveying exposed persons and conducting investigations in workplaces.

Changes to the HIV Rules and Regs

The Board additionally passed amendments to the Rules and Regulations Pertaining to the Reporting, Prevention and Control of AIDS, HIV Related Illness and HIV Infection which will allow local boards of health to determine their own policy regarding the retention of HIV negative public health reports. Previously, local health departments were required to adhere to the Colorado Department of Public Health and Environment's HIV negative record retention policy.

CDPHE policy requires personal identifiers and behavioral risk information to be delinked from negative HIV test results one hundred and twenty days following specimen collection and personal identifiers and negative test results to be destroyed after two years.

Under the new regulations local boards of health that adopt their own HIV negative record retention policy must provide opportunity for public comment and input through a public forum as part of the adoption process. The new regs additionally stipulate that local policies must address the following areas: 1) linkage of personal identifiers, behavioral risk information and results; time frames, if any for delinkage, 2) the availability of anonymous testing, 3) time frames for destruction of records, 4) method and supervision for destruction of records, 5) approval of record retention policy by the Colorado State Archivist, 6) procedures for hard (paper) records and electronic (computer) records, 7) procedures for records of negative results and positive results and 8) inclusion of record retention information in the client consent form. Consent forms developed at the local level must be approved by CDPHE. Finally, the new regulations require that every two years, local boards of health review their policy and consider the need for an anonymous HIV testing option in their jurisdiction, again with opportunity for public input and comment through a public forum.

A monthly report of current and ongoing activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.



BOARD HIGHLIGHTS

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - May 5, 1995

- Copic: Dr. Buckley reported on the differences in the types of policies offered to their clients now as compared to several years ago, using as a guide, several articles in the most recent *Colorado Medicine*.
- Medical Executive Group: Ms. Pennie Joseph reported on the recent retreat sponsored by Copic, indicating there were reports from the BME, a legislative update and a CMS report from Ms. Maloney.
- AMA: Dr. Joel Karlin introduced Daniel "Stormy" Johnson, M.D., AMA Speaker of the House. Dr. Johnson was present as the Keynote Speaker at the CMS Leadership Conference on May 6th & 7th.
- Board of Directors: The Board approved two motions to give money to the AMA, 1) a contribution of \$2500 to the AMA campaign for enactment of professional liability reform legislation and 2) a contribution of \$5000 to participate in the AMA Litigation Center, a clearing house of information between the AMA and state medical societies.
- The Board approved a proposal to form a working coalition involving CMS, labor groups, legislators, etc., to discuss the many sides of the health care question and attempt to agree on some legislative issues.

ATTENTION ALL WOMEN PHYSICIANS:

Are you a woman physician searching for a balance between work and your personal life? Do you want to build a better future for yourself as a woman and as a physician? Then you will want to attend the Fifth Annual Rose Medical Center Balance Conference. The conference will be held at the Westin Resort in Vail, August 10-13, 1995. For more information and registration call (303) 770-2220. CME credits 14.5 Category 1 AMA.



Health Care in America



Active participants in the national health care debate should keep in mind the maxim, "If it ain't broke don't fix it." While medical care in the United States is not perfect, and while some elements of the system could use some fine-tuning, America still offers its citizens the best health care in the world. In fact people come from around the globe to take advantage of America's technologically advanced and individualized health services, patients for the treatment, and doctors to learn. The medical care enjoyed in Colorado and around the country does not need major reform. What needs serious reform if not elimination is government involvement in health care. Government regulation of health care creates an inefficient bureaucracy. Furthermore a strong government presence in health care is the main reason for its prohibitive cost. Finally it is an infringement on our right to privacy.

One only needs to look at the United States Post Office, public school system, social security, Medicare and Medicaid and numerous other government programs to see the inefficient ways the government runs things. As other countries learn that state-run medicine does not work well, they move away from these programs.

Along with the start of Medicare and Medicaid came higher prices. We now have the government telling doctors how much they can charge for services. When we tell people in the medical field how much they can charge we really limit new

advances in technology and possibly the discovery of new life saving drugs. My son visited Israel, and on a trip to a doctors office found it's more than an hour and a half wait to possibly see a doctor. A good example of nationalized health care. After reading about Canada's health care problems, I think anyone can understand what we need is less government, not more.

Government intervention in our health care infringes on our right to privacy. If the government is paying for my health services, they will be deciding what kind of care I and my family will receive and possibly how to live my life. Medical records are very private and I'm sure patients wouldn't want government officials to be able to read them. A question I would be sure to ask is, "What happens to senior citizens who cannot afford health care?" Before the start of government programs, family, friends, churches and charitable organizations helped those in need. America could do it again. Once the government started doing what people used to do for themselves, we started to depend on it. The government takes way too much in taxes to finance all its programs. I for one would be much more willing to give to charitable organizations if my taxes weren't so high. As Henry D. Thoreau might say to America's health care providers if he were alive today and witnessing the health care debate, "Privatize, privatize, privatize."



Fifi E. Walker's essay, *Health Care in America*, received the \$200 Second Prize in the Colorado Medical Society's essay contest on health care reform. Mrs. Walker has lived in Colorado Springs since 1962. She graduated from Harrison High School in 1972. She and her husband Forrest will celebrate their twenty-third wedding anniversary in July.

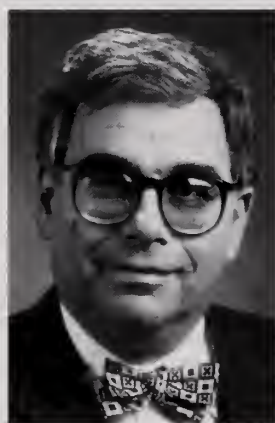
The Walkers have three sons, Gregg, age 22 and married to Rebecca, Chad, 19, and Jason, 15. Mrs. Walker has managed the Patrick Henry Elementary lunchroom for one year and says she really enjoys the children. Over the last several years she has become very interested in politics and the debate over health care.



School of Medicine Research:

Foundation of Expertise, Fiscal Survival

by Richard Krugman, MD



Richard D. Krugman, MD
Dean, University of Colorado
School of Medicine

When Dr. David Petijohn, CU biochemist, peers through his microscope at breast cancer tissue samples, he is looking for unusual sugars and carbohydrates on the cells. He hopes eventually to help oncologists predict which women, having been treated for small tumors, may experience recurrence of breast cancer.

When Dr. Kathryn Horwitz, CU endocrinologist, bent over her microscope a few years ago, she sought and found a way to determine which breast tumors were estrogen-dependent, greatly enhancing the ability of physicians to effectively treat their breast cancer patients.

These scientists are but two of hundreds of researchers on the campus of the University of Colorado Health Sciences Center. Each of their colleagues is engaged in intensive projects, both in basic research and in clinical research, aimed at discovering something which will help people stay or get well.

The record of this CU group of faculty is astonishing. Twenty years ago, CU Health Sciences Center faculty conducted \$25 million in research. They discovered that lymphocytes are pre-programmed to respond to antigens. They discovered that steroids can serve as immunosuppressants in transplantation. They defined adult respiratory distress syndrome. They identified the battered child syndrome.

More recently, they have explored pre-programmed cell death, shown that Vitamin E defi-

ciency causes neurologic symptoms in children with chronic cholestatic liver disease, and developed the world's first 3-D images of the human body derived from anatomical sections, now available on the internet.

The joint CU/Children's Hospital CVP team is now studying the use of nitric oxide therapy in premature infants with respiratory distress syndrome, children with respiratory failure, and children recovering from heart surgery or heart transplantation. These children are all currently treated with long-term ventilation, specialized therapies and long hospital stays. Such treatments and costs could be dramatically reduced if nitric oxide therapy is proven effective.

These projects and others will lead to more, better, less expensive ways to care for people who suffer illness or injury. In addition, the entire research effort will bring in \$133 million in extramural funding this year, creating about 5,000 Colorado jobs.

These activities and others, all part of the research mission of the institution, are the reason that the University of Colorado School of Medicine and University Hospital retain their specialized place in the Colorado medical economy.

However, while many are aware of our protocols and specialty surgery services, for example, many do not realize how dependent our medical school is on this research enterprise.

The State of Colorado now pays only 10 percent of the University of

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Colorado School of Medicine salaries paid to the faculty members who train our future doctors and researchers. Research and clinical work funds the remainder.

Because research plays such a key role in advancing medical science — and in funding our school — we pay a great deal of attention to it in our planning processes.

Eleven years ago, a half dozen years before I assumed responsibilities as dean, we identified the importance of providing infrastructure to three program areas: molecular biology, the neurosciences, and cancer. Today, similar retreats have us focused on new research initiatives: genetics, molecular structure, and health care outcomes. Fortunately for our students and for Colorado, we have extremely enterprising faculty who are remarkably successful in competing for grant monies that push forward these research initiatives while providing essential support for our educational programs.

There are many hospitals that are "teaching hospitals." They have residents and students (and also get significant federal pass through dollars to more than cover the costs of teaching). Many of these hospitals' CEOs like to say that this teaching mission makes them academic institutions. The core of our academic mission, however — our research — is what separates us from every other health care institution in Colorado. Research is our lifeblood. And, we hope, it will continue to provide a better life for our patients and yours.

"You can't tell the players
without a scorecard."

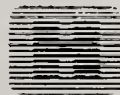
and **THE** scorecard is
the twice-monthly newsletter

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HCCA, 655 Broadway, Denver, CO 80203.

Prepared by Lorraine Heth, Program Manager
Dept. of Health Care Policy

Key: DP = Denver Post; CMC = Colorado Managed Care Newsletter; RMN = Rocky Mountain News; DBJ = Denver Business Journal;
C/M = Colorado Medicine; NYT = New York Times

• Sisters of Charity Health Care Systems, Inc. - Colorado Regionalization

Effective July 1, 1995, each of the following nonprofit corporations will be merged into The Penrose-St. Francis Healthcare System, which will be the surviving corporation and will continue under its new name, "Sisters of Charity Health Services Colorado": 1) Provenant Health Partners, 2) Provenant St. Anthony Hospitals, Inc., 3) Provenant Mercy Medical Center, 4) Penrose-St. Francis Health System, 5) St. Mary-Corwin Hospital of Pueblo, and 6) St. Thomas More Hospital and Progressive Care Center. (Letter to CMS 6/9/95).

• PorterCare Adventist Health System

July 1, 1995 Denver's No. 3 hospital system will be known as PorterCare, short for PorterCare Adventist Health System. The new name plays off the strong public image of Porter Hospital, the centerpiece of the Adventist hospital system. The hospital group also owns Littleton Hospital and Avista Hospital in Louisville, and manages five hospitals across the state. Terry White, CEO, states "This health-care market is in chaos and we felt that we risked getting lost if we adopted an entirely new name at this point. The other systems don't have very good name recognition with consumers; we wanted to take a different approach." (DP 6/6/95)

Meanwhile, the Adventists continue negotiations with Provenant Health Partners. White confirmed the hospital groups will keep their separate identities but create a new not-for-profit organization bringing various operations together. The hospital systems will also form a new for-profit group, with responsibility for running many of their facilities. That for-profit group will be 25% owned by the Adventists, 25% owned by Provenant, and 50% owned by its physicians, White said. Negotiations are expected to be complete within the next month. (DP, 6/6/95)

An important element of the potential joint venture will be for the maintenance of separate ownership by the two different religious groups, but the ability to act as a single entity in the marketplace. Reportedly the two groups represent over 20% of the admissions in Denver. (CMC 5/22/95)

• HealthONE, Columbia/HCA

A letter of intent has been signed to form a joint venture pooling the assets of HealthONE and Columbia/HCA. It will include all hospital and ambulatory care assets of the two groups. A broad range of medical groups will be affected by the joint venture. Columbia's Rose Health Centers and RMHC are currently moving into Columbia's Colorado Healthcare Management divisions.

Physician Organizations affiliated with Columbia include: Summit Physician Organization, Metro Group Medicine, Cherry Creek Associated Physicians, Rocky Mountain Health Centers and Premier Medical Group along with a psychiatric panel at Columbine named Beacon Behavioral Health. Physician Organizations affiliated with HealthONE include: Focus Health Services, Managed Patient Care and Total Patient Care. HealthONE has also fostered the development of three new primary care organizations for the purpose of Medicare Risk contracting: Aurora Associated Physicians, Colorado Associated Physicians at P/SL and a Swedish group which is being absorbed into Total Patient Care. Columbia would pay off HealthONE's \$360 million in debt and assume management of the joint venture. (CMC, 5/22/95)

The Federal Trade Commission is conducting an antitrust investigation of HealthONE's proposed partnership with Columbia/HCA Healthcare Corporation. The combination of HealthONE and Columbia/HCA would control more than 33 percent of the local healthcare market, becoming Denver's most powerful medical system. Its market force would be particularly evident in Aurora, where the group would control both general hospitals. Brad Bawmann, HealthONE spokesman said his hospital system anticipated an FTC investigation because of the proposed venture's

size, and that HealthONE would cooperate fully with federal regulators. He also noted HealthONE and Columbia informed the FTC of their plans just before the deal was announced, initiating discussions with the government agency.

(DP, 6/7/95)

• **Other News of Related Interest:**

Southern Colorado Health Plan Inc. expects to ask the Colorado Division of Insurance within the month for permission to greatly expand beyond its current five-county service area. Byron Cairns, president of Southern Colorado, said the 9-year-old HMO hopes to move into metro Denver, northern Colorado and further into southern Colorado. As of July 1, they will change their name to Foundation Health.

(DBJ)

The industry wide push to keep a lid on health care costs is driving the increasing popularity of managed care, a type of insurance that encourages health care providers to eliminate unneeded procedures, treat people outside the hospital and emphasize healthy lifestyles. Health care experts cite what's happening in California as a look at Colorado's future. There, under a system in which insurers pay a set amount per patient and providers must figure out how to make ends meet, the ratio is roughly one hospital bed per 1,000 patients. In Colorado, the ratio is about 2.9 beds per 1,000 patients. That means Colorado's hospital system faces more contractions.

(RMN, 6/8/95)

Further expanding across the Atlantic, Columbia/HCA Healthcare Corp. finalized a joint venture agreement to bolster its presence

in the London market. The Company's international operations have not grown beyond the two London hospitals and a Geneva, Switzerland, facility that it acquired in its 1993 acquisition of Galen Health Care Inc., a rival hospital chain based in Louisville, Ky. Columbia's London venture involves a pact with General Healthcare Group, plc, Britain's largest independent healthcare provider and a unit of Groupe Generale des Eaux, the French conglomerate with interests in healthcare and utilities. Terms of the venture weren't disclosed.

(WSJ 5/24/95)

NOTICE: The following resolution was passed at the 1995 Interim Meeting of the House of Delegates and is published here to be certain that all members of Colorado Medical Society are notified of this change in the bylaws.

"RESOLVED, that the Colorado Medical Society supports the sharing, by and between component societies, of information pertaining to the qualifications of physicians applying for membership in a component society, including information with respect to any past and pending complaints, investigations, disciplinary actions, grievance review proceedings, and grievance review actions, and that such information should be shared in confidence with the credentials committee or grievance review committee of the medical society to which the doctor is applying or transferring, with the understanding that all such information would remain strictly confidential and would be transferred for the purpose of promoting quality health care, monitoring the professional standards of physicians, and preserving patient safety; and be it further

RESOLVED, that the CMS Bylaws be amended as follows:..."

(Several sections of the Bylaws were modified to allow this information to be shared. It was not deemed necessary to reproduce all of the attendant changes. Anyone wishing a complete copy of the CMS Bylaws, as amended March, 1995, can obtain them by contacting the CMS offices.)



MEDICAL OFFICE AUTOMATION

*The computer's place in today's medical practice:
some helpful tips, experiences and guidelines for physicians*

Peter W. Peterson, M.D.,* Denver, Colorado
CMS Office Automation Subcommittee

The Hewlett Packard (HP) "Palmtop" some useful applications.

The **HP Palmtop**[®] is one of those organizers that is actually a computer. It is similar to other organizers in that it has an appointment scheduler, a telephone directory, a memo section, as well as a place to keep lists of handy items such as restaurants. However, it also allows for keeping medical information.

Today, before writing this article,

possibly for treatment

The other computer aspect of the **Palmtop**[®] which I use every day, is the **Lotus 1,2,3**[®] program. As a pulmonologist, I like to follow the results of my ventilator changes, to see if the changes result in improvement in the patient's spontaneous vital capacity, A-a gradient, compliance, ventilator pressure, respiratory rate etc. By making a spreadsheet on Lotus, I am able to input the data on a daily basis and in about 30 seconds. Then I can ask the computer to draw me a graph with trends in the items I want to follow. Once a week, I copy the contents of the **Palmtop**[®] onto my PC at home. This prevents me from losing data if my batteries go dead, or something else untoward happens. But also, by having the spreadsheets on my PC, I can print out the graphs and annotate them. It is a very useful documentation tool.

COMMENT: The **HP Palmtop**[®] isn't cheap, but it isn't prohibitively expensive. It has been very reliable. I've lost my data twice, with battery problems, before I learned how to avoid this problem. However, the second time, I had the back up copy and was able to copy from the PC onto the **Palmtop**[®], and restore my data. The **HP Palmtop**[®] is a very handy pocket sized computer.



The Hewlett Packard (HP) "Palmtop"

I looked up things on two occasions; one was to see what the glucose load was of a tube feeding formula. I was interested in that because the patient I was confronted with had a high carbon dioxide and high glucose loads which can cause this. (The formula was low in glucose.) The other item I needed to look up was the causes of Adult Respiratory Distress Syndrome (ARDS). I needed to know the viral and bacterial causes. Having this information at my fingertips allowed me to get started on my search for causes and

* Ed. Note: Dr. Peterson is an Internist specializing in pulmonary diseases and practices in Denver.

The Candidates



In 1995, Colorado Medical Society has seven elective offices to fill. Elections will be at the House of Delegates meeting in Aspen, Colorado, September 7-11, 1995. Individual candidates on the Nominating Committee's slate for these positions are profiled on the following pages. They are presented in no specific order, nor does their appearance in this magazine indicate any endorsement, support or solicitation for votes for any individual or group of candidates. The **CMS Bylaws (as amended by the Interim Meeting of the House of Delegates, March, 1995)** outline the procedure for candidacy and requirements for election to an office of the Colorado Medical Society:

Chapter VI - Officers and Other Elected Persons

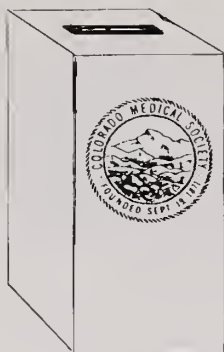
Section 1. Designation. The officers of the Society shall be the President, President-elect, Speaker, Vice Speaker, Immediate Past President, and the Treasurer, and Secretary. The House of Delegates shall elect Directors as provided in the Bylaws (Chapter X, Sections 1 and 2). The House of Delegates also shall elect Judicial Councilors and members of a CMS Grievance Committee (as provided by the Bylaws, Chapter X, Sections 1 and 2), and any Delegates and Alternate Delegates to the American Medical Association. Regardless of the terms of office, all shall serve until their successors have been elected and installed. Delegates and Alternates to the AMA may concurrently hold any elected office. The only office other elected persons may concurrently hold is that of Delegate or Alternate Delegate to the AMA.

Chapter XI - Elections

Section 1. Nominating Procedure.

a. The House of Delegates shall, from its accredited Delegates and Alternates, elect a Nominating Committee consisting of representatives from the Colorado Medical Society Districts as provided in the Bylaws. No member of the Committee may serve more than four consecutive one year terms. The Board of Directors shall select two Board members to serve as ex-officio non voting members of this Committee in addition to the elected members. The Committee shall be elected during each Annual Meeting. The Chair of the Nominating Committee shall be elected by a majority of the Committee members and may not serve in that capacity two consecutive years. The Nominating Committee shall hold an open forum at each Interim Meeting to hear prospective nominees. The Nominating Committee shall actively solicit recommendations from the component societies for all elected positions before each Interim Meeting. The Committee is to report its recommendations, which shall be carried in the House of Delegates handbook, to the first Annual Meeting following its election. The Committee shall be charged with the responsibility of nominating at least one qualified person for each elective office, including Judicial Councilors, but not Historian and members of Councils who are nominated by the Board of Directors, to be filled at the next Annual Meeting. In the event of multiple qualified candidates for any one office, the nominating committee shall not report a preference on submitting the slate.

Additional nominations may be made from the floor at any time.



COLORADO MEDICAL SOCIETY ELECTIONS

The Candidates

AMA Alternate Delegate

Joel M. Karlin, MD, believes the time has come for physicians and patients to take back control of our health-care delivery system. As CMS President-elect this year, Joel is helping to change CMS into a progressive, proactive force in Colorado healthcare with broad based member input.

Joel believes the "doctor-patient relationship" is the foundation of our healthcare system: doing what is best for our patients is doing what is best for our profession. Many of his efforts have been directed toward patient choice, physician fairness, and free market competition as witnessed by his participation in creating the CMS/CHMOA "White Paper on Physician Affiliation/Disaffiliation", the CMS legislative effort with our "Point-of-Service" bill, the "My Doctor, My Choice" program, and the newly formed CMS Patient Advisory Committee.

Joel has served 2 years as AMA Alternate Delegate, authoring successful resolutions on health system reform, managed care, patient advocacy, and ADA. He helped modify AMA policy on health system reform, moving towards individually selected and owned insurance.

As the only full-time practicing physician on the Colorado AMA Delegation, he is the first Colorado physician in almost 30 years to be selected for an AMA Council, having just been appointed by the AMA Board of Trustees to the Council on Legislation.



AMA Alternate Delegate

Dr. Rob Bogin came to Colorado in 1987 immediately following his fellowship. He received his training at the University of Pennsylvania, Cornell University Medical College, and the University of Michigan. He is board certified in internal medicine and pulmonary medicine. He presently is the medical director of MetraHealth.

Dr. Bogin has been active in organized medicine since medical school, and has been one of Colorado's AMA alternate delegates since 1991.

As Chair of CMS' Health System Reform Task Force, Dr. Bogin led a diverse group of physicians in defining the principles that CMS believed should be part of any health system.

He has been Secretary/Treasurer and Chair of CMS' Young Physician Section, and a member of the Council on Legislation. He's a member of COMPAC's Board, and an alternate delegate to CMS from Denver.

Nationally, Dr. Bogin was elected Chair of the AMA's Young Physician's Section in 1990. He spearheaded several community service projects, including a medical/legal clinic for the homeless, which received a national award from the American Bar Association. In 1992, he received an appointment to the Board of Directors of the AMA's political action committee, AMPAC. He is the youngest member in its history. Last year, he was appointed to their executive committee.



AMA Alternate Delegate

Dr. John O. (Jack) Cletcher, Jr., is an orthopedic surgeon in private practice in Longmont, Colorado. He received a BA from Harvard University, and his BS and MD from the University of Illinois and School of Medicine. From 1958 to 1964 he was a family practitioner in rural Illinois, following which he did an orthopedic residency at Denver General Hospital and since that time has been in private orthopedic practice in Colorado.

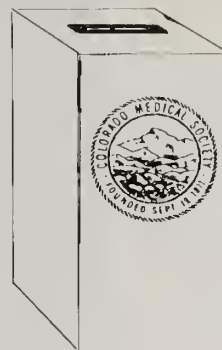
Dr. Cletcher has broad experience in organizational medicine on both local and national levels. He has been a member of the AMA since 1964 and CMS since 1965. He's currently a CMS Board member and a member of the CMS Executive Committee. He has served as President of the Boulder County Medical Society, the Colorado Orthopaedic Society and the local chapter of the Western Orthopaedic Association. He is a member of the American Academy of Orthopaedic Surgeons (AAOS), and has served on national and special committees and task forces. He was the Colorado representative to its Board of Councilors from 1989 to 1995, serving on the Board's Executive Committee. He is a member of numerous orthopedic societies.

Jack says "One of the most valuable lessons I have learned, as an AAOS Councilor is the importance of effective Colorado representation on a national scale.



COLORADO MEDICAL SOCIETY ELECTIONS

The Candidates



Speaker of the House

Ted Lewis came to Colorado in 1971 to begin his internship in Internal Medicine at UCHSC. His involvement in organized medicine began during his residency with election as representative



from the Department of Medicine to the house staff organization and membership in the resident's section of the Denver Medical Society and the AMA.

In 1977, he moved to Colorado Springs to start private practice, and quickly became involved in the El Paso County Medical Society, serving as president in 1989-90. With a long term interest in the problems of the indigent, he became involved in the community's struggling indigent health clinic, serving as its board president for three years. He has served on many community boards including the Arthritis Foundation, Citizen's Goals, Cheyenne Village, and is current president of the Cheyenne Mountain School District Board of Education.

He has been a member of the CMS for 20 years serving on the Board of Directors, Finance, Medical Indigent, Professional Education and Accreditation Committees, and was the first chairman of the Hospital Medical Staff Section. He was elected Vice-Speaker of the House of Delegates in 1993. Throughout his medical career he has been active in organizations advocating for physicians and patients to improve the health of all citizens.

Vice Speaker of the House

Dr. Louise McDonald, who is the Director of the University of Denver Health Service, received her MD from Georgetown University in 1966 and did her pediatric residency at Harbor General in Torrance, CA. Before



moving to Colorado in 1990, she practiced pediatrics in northern California for 20 years.

In California Dr. McDonald served as President of the Northern California Chapter of the American Academy of Pediatrics and as Secretary-Treasurer of the San Mateo County Medical Society. She participated on numerous committees of the California Medical Association, including the Commission on Legislation, and chaired the CMA Liaison Committee to the State Bar and the Women in Medicine Committee. In 1987 Dr. McDonald was elected to the California Medical Association Board of Directors and remained on that Board until she came to Denver.

Dr. McDonald currently sits on the Colorado Medical Society Board of Directors. She chaired the Colorado Medical Society Women in Medicine Section and the Corporate Practice of Medicine Task Force and served on the CMS Council on Legislation, the Health Systems Reform Task Force, and the Finance Committee. She is a member of the CMS Board of Directors and its Executive Committee.

AMA Delegate

M. Ray Painter. M.D., F.A.C.S., has been involved with organized medicine and the socio-economic issues of medicine for many years. He was chairman of the Council on Socio-Economics for the Colorado



Medical Society in the late '70s and recognized the importance of relative values to practicing physicians at that time. Consequently, he was actively involved in the start-up and development of *Relative Values for Physicians* published by McGraw-Hill. Recognizing the unfairness and inequities of the level of payments through RBRVS, he initiated a class action suit to correct this injustice in the Medicare reimbursement system.

In 1990, Dr. Painter founded **Physician Reimbursement Systems (PRS)** in order to assist doctors with increasing their incomes through proper and ethical coding. He understands the issues important to practicing physicians and has been willing to speak out on difficult and important matters. Dr. Painter has served as a CMS delegate to the American Medical Association since 1989. His continued involvement on a national level in coding, reimbursement and physician integration issues, coupled with his 25 years of private medical practice, makes him an excellent candidate to continue to represent you at the AMA level.

(Continued on following page)

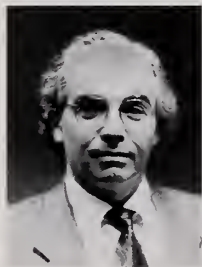
The Candidates

(Continued)

Quinn elected to AMA Constitution & Bylaws Committee

AMA Delegate

Mark A. Levine, MD, is a board-certified internist who has spent over 25 years in the practice of General Internal Medicine. After training at Temple and Penn, he completed his medical training at the University of



Colorado Health Sciences Center. Active in many aspects of service to physician communities, he is a member of the Board of Directors of the Colorado Foundation for Medical Care and of Denver's HealthMark Centers, Inc. He is a former president of the Colorado Society of Internal Medicine and now serves the American Society of Internal Medicine on its Health Care Reform Committee. He has been Chief of the Department of Medicine at Swedish Medical Center and is quite active in the Arapahoe Medical Society which he now serves as chair of its delegation to CMS.

Dr. Levine has extensive experience in managed care, physician risk management, credentials, quality programs and utilization review from his role as Medical Director for managed care services for Focus Health, a 70 member group practice in the Denver metropolitan area.

Mark has served on Colorado's AMA delegation for 6 years and has been an active contributor to the AMA process, sponsoring several resolutions and serving on several AMA committees.

Next Issue:

Candidates for President-elect

Dr. Richert E. Quinn, Physician Risk Manager of Copic Insurance, was elected to the AMA Constitution and Bylaws Committee at the Annual Meeting in Chicago. Dr.



Quinn, a surgeon from Greeley, Colorado, made a hard run against the incumbent Francis I. Kittredge, MD, JD, which made it doubly difficult. In fact, the first ballot was close enough that a runoff was held. In the second polling, however, Dr. Quinn won a hands-down victory.

This is a major step for Colorado, since Dr. Quinn's election to an AMA post is the first of a Colorado physician in the past nineteen years.

Dr. Quinn has served as a Delegate to the AMA for ten years, and has been the Senior Delegate the last five. He has served 10 years on the CMS Organizational Study Committee, a member of the Constitution & Bylaws Committee of the Northern Colorado Medical Center. He also served as President of CMS in 1984-85, and was a member of the Board of Directors of Copic Insurance Company and of the Colorado Physicians Health Program.

Dr. Quinn served as Medical Director of the Greeley Medical Clinic, as Examiner for the American Board of Surgery. He is a member of the American College of Surgery, the Southwestern Surgical Association

and the American Burn Association. He also served as chairman of the Colorado Coalition for Tort Reform, a highly successful effort which achieved professional liability tort reform in Colorado, one of the first states to rewrite its tort law, and which legislation has served as a model for numerous states since that time.

A Little History about Colorado and the AMA

In 1976, Dr. Robert E. McCurdy, a Denver surgeon, was elected to the Council on Medical Service of the AMA. McCurdy served as an Alternate Delegate and Delegate to the AMA from 1963 to 1985, and was chairman of the Colorado delegation for eleven of those years.

Bob McCurdy was also a Delegate to the CMS House of Delegates for 14 years, served 7 years on the CMS Council on

Legislation, was a member of the Constitution, Bylaws and Credentials Committee and the Medical Facilities Committee, and did stints on the Governmental Relations and the Public Relations Committees. He was described as a





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P racticing on a Desert Island?

by Michael P. Thompson

*A review of a useful book
by CMS member Marc
Ringel, MD*

cannot possibly know everything you are expected to know, by patients, by colleagues, by subordinates or by the governing authorities. Many times you cannot fully remember what you do know. What can you do?

One good place to start is a small book called *Accessing Medical Information From a Desert Island with Telephone Service*. Family Practitioner and 10-year CMS member Marc Ringel, MD has compiled an excellent, comprehensive, yet short book, containing all you need to know to get control of your information needs. The desert island from which he speaks is a lovely small community in Eastern Colorado called Holyoke.

Start at the beginning. You forgot much of what you learned in medical school when the test was over. Dr. Ringel gives some excellent information on what reference books you should own and what others to which you should have access.

You have a pile of journals in your office three feet high that is causing acute guilt complications. Which subscriptions should you cancel and how do you get control of the information in the others? This book has the answer. Dr. Ringel also tells you how to file pertinent information so you can find it when you need it, without your becoming a file clerk.

In today's information age, it is no longer possible to ignore the management of information by computer. Dr. Ringel avoids confusing you with the bits and bytes and RAM and all that, but still manages

to communicate clearly what kind of computer system you should have to meet your information needs in the modern day. The only real shortcoming in the whole book appears here. Dr. Ringel uses actual numbers that were very useful at the time of his writing, but have been outmoded in the short time since. For instance, the 80486 computer he talks about has been superseded by the Pentium and the newer PowerPC based computers. It's a small shortcoming that a good computer vendor or consultant can remedy for you. He even tells how to find one of those.

(Note: At press time, we were made aware that Dr. Ringel has updated this chapter and the revised version will appear soon. An advance copy of the revised section shows that he has rectified these deficiencies, and has also added some useful information on the Internet, as well as additional citations in the very useful annotated bibliography.)

Dr. Ringel singles out people as your single most valuable resource and notes that lack of a colleague to bounce things off of is one of the most common complaints of physicians who practice in a "desert island" situation. He offers remedies for that problem and information on how to manage consultations and referrals as well.

This 82 page book is published by Desert Island Press in Greeley and you can read in an hour or so, or digest it for several days then refer back to it again and again. Call Casey at 970-356-3221 or send \$14.95 to Desert Island Press, PO Box 2421, Greeley, CO 80632.

An estimated 75,000 articles accrue to the world's biomedical literature each week. How many have you read? Did you know that today's courts are assuming that medical information is more or less evenly distributed nationwide and are not allowing much leeway for "local" standards of practice? Were you aware that physicians use outmoded treatments because they are not up on the latest information and that family physicians can average about seven unanswered questions by the end of the day?

You know the reality that you



New Regulations on Patient Rights and Patient Grievance Mechanisms Adopted By the Colorado Department of Public Health and Environment

After hearing extensive public testimony, the Board of Health, at their November, 1994 meeting, passed amendments to the Standards for Hospitals and Health Facilities, Chapter II, Parts 6 and 9 - Patient Rights and Patient Grievance Mechanism. The Patient Grievance Mechanism requirement applies to all facilities licensed by the Colorado Department of Public Health and Environment (CDPHE). The patient rights regulations apply to those facilities licensed by the CDPHE not already covered under other existing regulations. (see list and exemptions below)

Patient Grievance Mechanism

The Patient Grievance Procedure section of the policy states that each facility shall post notice, in a conspicuous place in the facility, of the existence of its internal grievance procedure. The notice shall also inform patients, or their legal representatives, that if still dissatisfied with physician, dental, or podiatric patient care services, excluding fee disputes, a complaint may be filed with the Colorado State Board of Medical Examiners, the State Board of Dental Examiners, and the Colorado Podiatry Board. Upon request, the facility shall provide the patient, or the patient's legal representative, with the address

of the appropriate board and inform such person that these board are prohibited from arbitrating or adjudicating fee disputes between licensees or between licenses or between a licensee and any other party, pursuant to sections 12-36-104.5, 12-35-107.5, and 12-32-104.5, C.R.S.

Patients Rights Regulations

The regulations which emerged state that any facility licensed by the state shall provide to patients, upon admission, a disclosure of its policy on patients rights. The disclosure shall be made available through the use of an appropriate communication medium and in a manner understood by the patient, or the patient's legal representative.

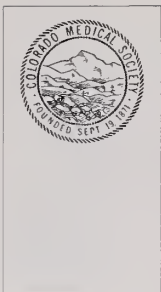
The regulations will apply to the following facilities: General Hospitals; Rehabilitation Centers; Convalescent Centers; Chiropractic Centers; Maternity Hospitals; Dialysis Treatment Clinics; Rehabilitative Nursing Facilities; Psychiatric Hospitals; Ambulatory Surgical Centers; Hospital Units; Birth Centers; Community Clinic and Emergency Centers; Community Mental Health Centers; Small Rural Hospitals

CDPHE-licensed facilities exempted from the patient rights section of the regulations are those which already have patient rights policies pursuant to section 25-1-120 and 6 CCR 10-1, Chapter V, Chapter VII, Chapter VIII, Part 5 and Chapter XXI. These include: long term care facilities, personal care boarding homes, residential facilities for the developmentally disabled,

and hospice.)

The regulations require that patient rights policy statements include the following information:

1. Billing Procedures - The patient, or the patient's legal representative has the right to be informed, upon request, prior to the initiation of care or treatment that is non-emergent, of the charge(s) for service(s) that is routine, usual, and customary; or the estimated charge(s) for service(s) based upon an average patient with a diagnosis similar to the tentative or preliminary admission diagnosis of the patient being admitted; and, based upon insurance information supplied by the patient, to be given assistance obtaining an estimate of any co-payment, deductible, or other charges that will not be covered by a third party payer and must be paid by the patient; and, the right to be informed prior to the initiation of care or treatment of the facility's general billing procedures. A facility may include a disclaimer with the disclosure of any charges. Such disclaimer may include further information on variables which may alter any disclosed charge. If charges to the patient are prohibited by law, or by third party payer contract, then a disclaimer of no charge shall meet the requirements of this paragraph;
2. Informed Consent - The patient, or the patient's legal representative has the right to give informed consent for all treatments and procedures. According to these regulations, it is the physician's,



dentist's, or podiatrist's duty to obtain informed consent. For the purposes of this regulation, the term "informed consent", shall include, but not be limited to, the following:

- (a) an explanation of the recommended treatment or procedure in layman's terms and in a form of communication understood by the patient, or the patient's legal representative;
 - (b) an explanation of the risks and benefits of a treatment or procedure; the probability of success, mortality risks, and serious side effects;
 - (c) an explanation of the alternatives with the risks and benefits of these alternatives;
 - (d) an explanation of the consequences if no treatment is pursued;
 - (e) an explanation of the recuperative period which includes a discussion of anticipated problems and the anticipated length of the recuperative period; and
 - (f) an explanation that the patient, or the patient's legal representative, is free to withdraw his or her consent and to discontinue participation in the treatment regimen.
3. Physician Involvement in Research - The patient or patient's legal representative must be informed if the facility or the patient's physician, dentist, or podiatrist is participating in teaching programs and/or in research, and experimental or educational projects

relating to the patient's own case.

4. Patient Involvement in Decisions - The patient has the right to participate in all decisions involving their care or treatment.
5. Information on Providers - The patient has the right to know the names, professional status, and experience of the staff that are providing their care or treatment.
6. Refusal of Treatment - The patient has the right to refuse any drug, test, procedure, or treatment consistent with other state and federal statutes; and to be informed of the probable or likely medical consequences of this action.
7. Respectful Care - The patient has the right to care or treatment that is respectful, recognizes a person's dignity, and provides for personal privacy to the extent possible during the course of treatment.
8. Facility Regulations - The patient has the right to be informed of the facility's rules and regulations as they apply to the patient.
9. Grievance Procedure - The right to be informed of the facility's grievance procedure.

The regulations cited above became effective May 1, 1995.

Injury Epidemiology and Prevention

The Injury Epidemiology Program and the Injury and Disability Prevention programs of the Colorado Department of Public Health and Environment have recently completed publication of a series of

monographs on the occurrence of selected types of injuries in Colorado:

- spinal cord injuries
- burns
- carbon monoxide poisoning
- suicides
- traumatic brain injuries

Public health surveillance systems have been developed for each of these conditions during the past 5 years. Each monograph contains information on the epidemiology of the condition in Colorado, provides the frequency of events by county, and describes prevention efforts led or funded by the Department.

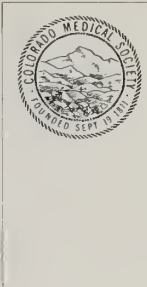
To obtain a copy of any or all of the monographs, telephone, fax, or write to Angela Garcia at:

Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South DCEED-ADM-A3 Denver, CO 80222-1530 phone - 303-692-2649 fax - 303-782-0904

New Rose Health Care Center For Seniors

Rose Health Care Centers has opened a new medical practice located at 9450 E. Mississippi Avenue on the southwest corner of Mississippi and Clinton.

Headed by CMS member Robert McCartney, M.D., a specialist in internal and geriatric medicine, and Todd Ogawa, M.D., also an internal medicine specialist, the new center provides comprehensive primary care services for adults and seniors.



The physicians will accept Medicare and also participate with Senior Risk Plans, including FHP/Comprecare HMO Senior Plan, CIGNA Health Care for Seniors and Senior First HMO and many others.

"Seniors like the idea of having a program that is designed specifically for them," says Dr. McCartney. "By participating with many of the senior HMO plans, this new center allows seniors easy access to comprehensive services that focus on helping adults of any age maintain a healthy lifestyle".

Services provided at the new location will include:

- Health consultations and annual exams
- General health screenings, including hypertension, diabetes and cancer
- On-site x-ray, lab tests, EKGs, hearing testing and minor surgery
- Family consultations on the subjects of independent living, long-term care, home health care and hospice care
- Memory disorder evaluations, diagnosis and primary care follow-up
- Complimentary medication consultations with a pharmacist
- Coordination of transportation services

"We can provide patients with all the services they need, short of hospitalization, at one location," notes Dr. Ogawa. "Our goal is to provide a continuum of coordinated care throughout all of the living changes that older adults experience."

For more information, call 696-0313.

American College of Surgeons Requiring TNM Staging by Physicians

The Cancer Committees, tumor registries and medical staff of the 20 Colorado hospitals with approved cancer programs are preparing to meet a new requirement by the American College of Surgeons Commission on Cancer. Effective January 1, 1995, American Joint Committee on Cancer TNM staging must be documented on the medical record by the managing physician.

The managing physician has access to all clinical information and is best able to integrate all data appropriate for patient management. Each hospital will be involving all members of the medical staff who diagnose and/or treat cancer patients to establish procedures based on its own needs.

For further information about this requirement, contact:

American College of Surgeons, Commission on Cancer, M. Asa Carter (312) 649-7080, Carol Hahn Johnson (312) 664-4050 ext. 229

Colorado Tumor Registrars Association, Public Relations Committee, Nancy Larkin, CTR (303) 629-3612, Kathye Howell, CTR (303) 344-7075, Bonnie Mather, CTR (303) 399-8020 ext. 3706, Randi Rycroft, CTR (303) 692-2550.

Portability Featured in Spots

Bert A. Loftman, MD of Atlanta, Georgia has produced a public service announcement which raises the question of why health insurance is tied to jobs. He says many radio stations will air the spots for free if a non-profit organization (such as a county medical society) requests it. The ads advocate giving tax breaks on health insurance to individuals, as well as employers. For more information call Dr. Loftman at 404-351-4373.

Free Book on Alzheimer's Disease

The Advisory Panel on Alzheimer's Disease has issued a special report to Congress giving recommendations for public policy on legal competency judgments in cases of probable Alzheimer's disease and other related dementias. Call the Alzheimer's Disease Education and Referral Center at 800-438-4380 and ask for publication No. Z-86.



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03/0795

MEDICAL DIRECTOR - Regional hospital in south-central Colorado seeks experienced BC/BE physician for 1/2 time position. Strong organizational, communication and management skills essential. Qualified candidates please send CV to Paul Herman, CEO, San Luis Valley Regional Medical Center, 106 Blanca, Alamosa, CO. 81101.

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Luxurious medical office for lease or sale, ideal for surgeon, internist, chiropractor or dentist. Will lease furnished or unfurnished, lease option to buy, or sell outright. 2500 square feet, tongue-and-groove aspen wood throughout, large fish tank in wall, 4 exam rooms, large cast room with 3 bays, 300 MA X-Ray machine, 3 minute processor, Versys computer for billing, with 3 terminals, beautiful office furniture, excellent parking facilities, 2 blocks from Lutheran Medical Center, will sell furnished or unfurnished. \$175,000 or best offer.

Would sell office furniture, X-Ray machine, processor, and all X-Ray equipment, office furniture, typewriters, miscellaneous office equipment separately.

Contact: Kenneth Adler, MD Beeper: 780-1874 or call 425-5063. Please leave a message, I will call back.

2/0795

STAFF PHYSICIAN: Two openings for individuals with board eligibility/certification in family practice and experience in occupational health, at the University of Colorado Student Health Center, Boulder campus. The facility is accredited by JCAHO, serves 24,000 students as well as faculty, staff and dependents, and is located in a progressive, highly educated and diverse community. **Compensation:** Competitive salary, excellent benefits and vacation, CME opportunities and paid malpractice insurance. **Start Dates:** Oct. 1, 1995; Jan 2, 1996. **To Apply:** Contact the Medical Staff Office, Wardenburg Student Health Center, University of Colorado, Campus Box 119, Boulder, CO 80309-0119 (303) 492-5101. Applications will be reviewed starting June 1 and continue until positions are filled. The University of Colorado at Boulder has a strong institutional commitment to the principle of diversity in all areas. In that spirit, we are particularly interested in receiving applications from a broad spectrum of people, including women, members of ethnic minorities, disabled individuals, veterans and veterans of the Vietnam era.

1/0795

INTRACORP is one of the largest national Health Care Management companies and is dedicated to quality service delivered by a committed professional staff. We are currently seeking board certified physicians to work out of their offices as Utilization Review Physician Advisors. All specialties welcomed. Call Director of Medical Affairs at (800) 237-0377 x4350

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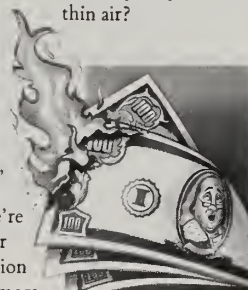
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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

"In passing. . . someone needs to note. . ."



What's wrong with this picture?

The other day it hit home when one of the CMS members came by the office to say "Good bye". He is just closing his practice. He is **not** quitting to move on to other exciting challenges or retirement and relaxation. He is a solo practitioner in what has been a high-demand specialty and he is probably at the very peak of his (cost-effective) proficiency in this field. He has been a very good (active) member of CMS for over 31 years. I can look back on most of those years and recall him in the variety of "good, active member" roles, from the OR to the committees and councils and the House of Delegates. I've seen him at all stages.

The doctor said he had sent his patients a letter telling them of his decision and that, as of a certain date, they should look to other caregivers. He said his wife had agreed to wrap things up at the office while

he went off to do locum tenens for a couple of months and sort things out.

What's wrong with this picture? Put it under a magnifying glass and several of the unseens show up: it takes \$5,000 just

to open his office doors (before he sees a patient) the first day of each month; he's getting fewer patients and smaller fees while business costs increase; up to 30% increase in administrative detail and non-medical office procedure required for each patient; continuing diminishment of the science and art of medicine in the path of increasing "corporatization" of so-called "consumer care"; inability to sell the practice or attract a partner to share or take over. Those are a few of the flaws in the picture.

Multiply this same picture by 2,000 and you get some idea of the ailments of the CMS membership right now, the first day of this month. Sure, costs, patient load and other

things vary, but the picture is still generally the same.

Is there anything we, as a professional society, can do about the picture? We keep asking the membership the same questions. We have already initiated a few things, re., just this year the Colorado Physician's Network (we'll soon know if that will work or will help); the CMS/Colorado HMO Association Joint Committee on working relations between physicians and HMOs; legislative efforts in the "My Doctor, My Choice" and HB 1262 initiative; a strong lobbying effort and physician testimony in as many as 60 health-related legislative proposals in 1995; and, widespread communications efforts to inform both the lay public and regulatory/legislative activists of the patient's untenable position in the face of wholesale healthcare change.

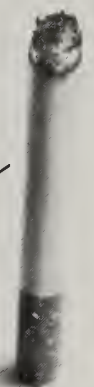
Change is here; there is no question and no one argues about that. All of this is going to hit home for a lot of people, but it will probably be too late for any positive effect.

In passing, however, someone needs to note the long years of selfless, caring service so many of the CMS members have given with all their heart, both to the public and to their peers, in the protection and delivery of the highest quality medicine available anywhere in the world.

Thank you to the vast majority of those wonderful individuals. You know who you are. Meantime, we'll keep trying to uphold medicine for the patient's sake.



*"Nah,
I've smoked
for
30 years.
It's too late."*



*"I've tried a
million times,
but I just
can't."*



*"I'll
quit
next
week."*



*"I'll quit
next year."*



*"What difference does
it make? I'm already
52 years old."*



*"It's one of the
few pleasures
I have left."*



*"I've got
other things
to worry about."*



*"The damage
is done."*

They know why they can't. Now tell them how they can.

Too many older smokers are still making excuses instead of making a determination to quit. And while most of them know about the more common long term effects of smoking, far too few of them know the facts about the immediate health benefits of quitting.

As a doctor, you can play a unique role in getting your older patients who smoke to quit for good. Take a little extra time and educate your patients about the immediate benefits of quitting. Like a decreased risk of heart attacks and strokes. Improved circulation. And most of all, the years they can add to their lives.

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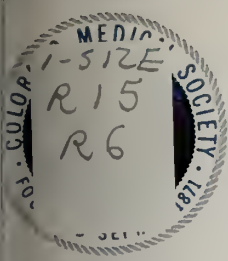
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August, 1995

Volume 92, Number 8

AUG 21 1995

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See: President's Letter "Fish. . . or be bait."

In This Issue:

Fish or Be Bait!	David C. Martz, MD, President
Reorganization of CMS	Mark Levine, MD
Doctors, Patients, Medicare and Republicans	Robert D. McCartney, MD
Final Annual Meeting Preparations	Page 281ff

You spent over
8 years in school,
over 300 all-nighters studying,
4 years in residency,
countless years working 7 days a week,
thousands of hours on call,
who knows how much in tuition,
and an unspeakable amount
in student loans.

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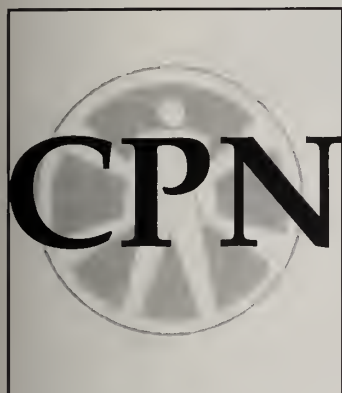
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COLORADO MEDICINE

August, 1995

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Historic agreement between the Colorado Physician Network and Rocky Mountain HMO. See page 271.

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Rehab News

NovaCare Offers New Rehab Program for Post Breast Surgery Patients

It's a well known fact that the leading cause of death for women age 35 to 54 is breast cancer. Last year, there were more than 182,000 new cases of breast cancer in the United States with 1900 of them occurring in Colorado. Despite much publicity regarding the prevention and treatment of breast cancer, little attention has been given to complications which may develop after surgery. Potential complications after breast surgery include pain, shoulder dysfunction, difficulty performing normal daily activities, lymphedema and emotional distress.

NovaCare Outpatient Rehabilitation, the nation's leading provider of outpatient physical therapy services, developed a new program designed to help women return to normal function and well-being after breast surgery. Studies have shown that physical therapy treatment after surgical intervention, whether it be a lumpectomy or mastectomy, can help facilitate a woman's recovery from breast surgery. The program "Physical Therapy after Breast Surgery" was developed by Felicia Krieger, PT, ATC, at NovaCare's Southeast center in Denver.

"This program really benefits women by safely and quickly rehabilitating physical limitations, as well as educating women on the prevention of future complications," said Krieger. "We accomplish this through various stretching and strengthening exercises as well as Manual Lymphatic Drainage to help improve function with daily living activities. Prior to completion of the program, patients receive education and instruction on a home exercise program to help them continue their rehabilitation confidently on their own."

The program has been well received in the Denver market and is being rolled out in other NovaCare markets across the country. Physician referral is necessary in most cases. "If a woman finds she is having limitations physically or emotionally after surgery, she needs to communicate that with her physician," concluded Krieger.

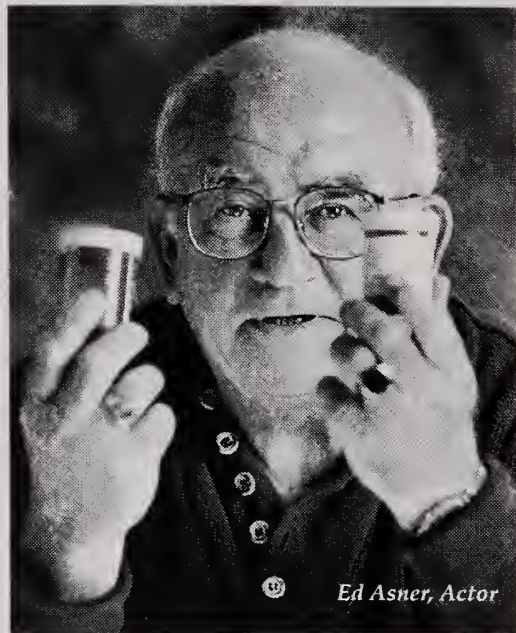
For more information about the program, contact Felicia Krieger at (303) 759-1063.

NovaCare Outpatient Rehabilitation is a division NovaCare, Inc., the leading rehabilitation management services company in the United States.



NovaCare
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(303) 696-6566

Attention: Physicians



Ed Asner, Actor

Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

The next time you prescribe a medicine, ask your patients:

"What other prescription and nonprescription medicines are you taking?"

A public service message from the National Council on Patient Information and Education (NCPPIE) and the U.S. Administration on Aging

Write for *free information* on patient medicine counseling.

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✠ ✠ NCPPIE
✠ ✠ 666 Eleventh Street, NW
Suite 810
Washington, DC 20001

CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax®

by **Montgomery Little and McGrew, P.C.**

legal counsel to the Colorado Medical Society

Candidates for President-Elect—Annual Meeting 1995

(For background, see *Colorado Medicine* for July, 1995, pp 251ff)

The decisions made in Congress,



and changes made at a state level over the next two years, will shape our industry for the next thirty years. **Terry Sullivan, MD**, is excited to run for

president-elect of the Colorado Medical Society at this critical time for Physicians and the delivery of health care in America.

Dr. Sullivan has practiced medicine in Colorado for sixteen years. These years have been divided between clinical internal medicine/public health, and administrative medical practice. He has worked with Health and Hospitals, the Colorado Department of Health, multispecialty group practice, Blue Cross Blue Shield, and is currently President, CEO, and Medical Director of a workers' compensation, managed care TPA.

Dr. Sullivan has served as President/Chairman of the Denver Medical Society, Board of Directors of CMS the past six years, Treasurer the past four, and is currently a trustee of the Employees' Pension Fund. In 1986 he was appointed by Governor Lamm to the Certificate of Need Board, and since 1993 has been a member of Board of the Colorado Department of Health. He looks forward to sharing his plans for CMS with you over the next few weeks and would appreciate your support.

Eugene Sherman, M.D. believes

**Photo
Not
Available**

he can provide the CMS and its membership a unique background based on his experiences in managed care,

hospital medical leadership, and in the development of integrated delivery systems and therefore enters the race for President-elect of the Colorado Medical Society.

Dr. Sherman has been a CMS member for 18 years. He has extensive experience in the areas of quality assurance, credentialing, and strategic planning. He has served over 10 years as a physician representative on the board of the largest IPA-model HMO in the state.

His recent academic studies include areas such as quality management, managed care, healthcare financing, and service excellence at Denver University. He currently serves as faculty member and active teacher in the Division of Healthcare Systems at the University College at Denver University.

Dr. Sherman has broad experience as an active participant in healthcare as a medical staff leader. He has been a student of managed care as it has grown in this state and demonstrated leadership and management skills in numerous medical and nonmedical organizations. His understanding of the issues and vision for the CMS will prepare us for the future of healthcare.

Dr. M. Ray Painter received his



MD from Medical College of Alabama in 1961, served in the U.S. Army from 1961 to 1970, established a solo urology practice in Grand Junction,

which developed into a four-doctor practice. He served as CMS-AMA alternate delegate from 1985 to 1989, and an AMA delegate since 1989.

Ray Painter has been a member of the CMS Council on Legislation since 1993. Ray Painter chaired the Long Range Planning Committee from 1983 to 1988, was chairman of the Council of Socio-Economics from 1978 to 1982, and chairman of the Health Planning Committee from 1974 to 1978. He has also served as president of the Mesa County Medical Society and president of the Western Slope Physician's Association.

In 1990, Dr. Painter founded **Physician Reimbursement Systems (PRS)** in order to assist doctors with increasing their incomes through proper and ethical coding. He understands the issues important to practicing physicians and has been willing to speak out on difficult and important matters. Dr. Painter's continued involvement in local, state and national organized medicine, coupled with his 25 years of private medical practice, makes him an excellent candidate for CMS President-elect.



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, PC. This column is not legal advice, but is for general information only. For help with specific problems, readers should consult an attorney.

Legislative Update

On July 1st of each year, laws change. Some of the laws enacted in the last legislative session impact the medical profession, including the following:

The Corporate Practice of Medicine: Before July 1, 1995, only hospitals in "rural" locations (counties with populations of less than 100,000) could employ physicians. In 1995, the statute was amended to allow any licensed or certified hospital to employ physicians, subject to certain limitations.

The limitations referred to have been amended to provide additional safeguards for the physicians and patients doing business with hospitals employing physicians. Hospitals employing physicians may not limit or otherwise exercise control over the physician's independent professional judgment concerning the practice of medicine or diagnosis or treatment. Hospitals employing physicians may not require physicians to refer exclusively to the hospital or to the hospital's employed physicians.

Hospitals which knowingly or recklessly limit or control a physician in these respects will have violated hospital standards of operation and may be held liable to the physician, or to the patient, or to both, for such violations, including proximately caused damages.

The law expressly reserves the hospital's right to make decisions with respect to the availability of services, technology, equipment, facilities, or treatment programs.

The law has also been amended to require hospitals to amend their medical staff bylaws and policies, and their hospital policies to prohibit discrimination with regard to credentials or staff privileges on the basis of whether a physician is an employee of, a physician with staff privileges at, or a contracting physician with the hospital.

Any hospital that discriminates with regard to credentials or staff privileges on the basis of whether a physician is an employee of, a physician with staff privileges at, or a contracting physician with, the hospital shall be deemed to have violated hospital standards of operation and may be held liable to the physician for such violations, including proximately

caused damages.

Hospital employing physicians are required to implement a procedure by which complaints by physicians alleging a violation of this law may be heard and resolved, and the procedure must preserve due process rights of the parties involved.

Other remedies are also available to the physician and patient alleging a violation of this law.

Reference: CRS § 25-3-103.7, effective July 1, 1995.

Mandatory Reporting of Domestic Abuse: The Medical Practice Act requires physicians and other health care professionals to report classes of injuries including bullet and gunshot wounds, powder burns and other injuries arising from the discharge of a firearm, a knife, an ice pick, and other sharp instruments, which the physician believes were intentionally inflicted upon the patient.

Under the amended statute, physicians are also required to report to the police where the physician is located, any other injury which the physician has reason to believe involves a criminal act, *including injuries resulting from domestic violence*.

"Domestic violence" is defined as an act of violence upon a person with whom the actor is or has been involved in an intimate relationship. Domestic violence also includes any other crime against a person or any municipal ordinance violation against a person when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship.

An "intimate relationship" means a relationship between spouses, former spouses, past or present unmarried couples, or persons who are both the parents of the same child regardless of whether the persons have been married or have lived together at any time.

A physician who fails to report commits a class 2 petty offense. If convicted, the physician will be punished by a fine of not more than \$300 or by imprisonment in the county jail for not more than 90 days, or by both fine and imprisonment.

Reference: CRS § 12-36-135, effective July 1, 1995

Delegation of Authority to Prescribe Controlled Substances: The statute allowing physicians to delegate to a physician assistant certain acts which constitute the practice of medicine, has been broadened. Under the amended statute physicians may delegate to a physician assistant *the authority to prescribe medication, including controlled substances*, and to dispense such drugs as designated by the board.

Reference: CRS § 12-36-106, as amended.

Expanded Definition of "Unprofessional Conduct" The definition of unprofessional conduct under the Medical Practice has been expanded to include the following additional acts:

Resorting to fraud, misrepresentation, or deception in applying for, securing, renewing, or seeking rein-

Medico-Legal News (*continued*)

statement of a license to practice medicine in this state or any other state, in applying for professional liability coverage, required pursuant to section 13-64-301, CRS (the Health Care Availability Act), or privileges at a hospital, or in taking the examination provided for in this article;

Any conviction of an offense of moral turpitude, a felony, or a crime that would constitute a violation of this article. For purposes of this section of the statute, a "conviction" includes the entry of a plea of guilty or nolo contendere or the imposition of a deferred sentence.

Any act or omission which fails to meet generally accepted standards of medical practice. This section previously referred to "an act or omission constituting grossly negligent medical practice or two or more acts or omissions which fail to meet generally accepted standards of medical practice." That language has been omitted from the amended section. A single act or omission constituting simple negligence now constitutes unprofessional conduct.

Engaging in a sexual act with patient during the

course of patient care or within six months immediately following the termination of the physician's professional relationship with the patient.. "Sexual act", as used in this section means sexual contact, sexual intrusion, or sexual penetration as defined in other statutes.

Failing to accurately answer the questionnaire accompanying the renewal form as required by statute. CRS § 12-36-123 ((1)(b)).

Failing to establish and continuously maintain financial responsibility, as required by the Health Care Availability Act. CRS § 13-64-301.

Failing to respond in a timely manner to a complaint relating to the conduct of a physician, made by a person or by the Board under the Medical Practice Act. CRS § 12-36-118.

Advertising in a manner that is misleading, deceptive, or false.

For the answers to questions about other changes in the laws affecting physicians, call Montgomery Little & McGrew, PC.

Reference: CRS § 12-36-117, as amended.

Puttin' on the Ritz is the theme for this year's Dinner Dance at the Annual Meeting



Black tie, business attire, or something in between - the choice is yours !

Come, enjoy dinner with friends and colleagues, then listen and dance to the music of the Sirens.

The goal for the evening is to have a great time!

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Advisory Council on Health Programs for Women and Children

Regular monthly meeting.

For information call Suzette Clark at (303) 692-2421.

Colorado Department of Labor and Employment

Worker's Compensation Level II Re-accreditation

August to November, 1995

Denver, Grand Junction, Colorado Springs

Faye Boyd, 303-575-8756

Coors

Coors Classic Charity Golf Tournament

For the benefit of Mi Casa Resource Center for Women, Children's Hospital Pediatric AIDS Unit and Seniors! Inc.

August 18, 1995

West Woods Golf Club, Golden, CO

Contact: Annette Noren at 277-5867 or Monica Martin at 277-5018

International Meniere's Disease Research Institute

8th Annual Electrocochleography/Otoacoustic Emissions/Intraoperative Monitoring Seminar,

August 2-6, 1995 Denver, CO.

Contact: Jane Wells or I. Kaufman Arenberg, MD.(303)778-4235

Colorado Physical Therapy Institute

Legal Boundaries of Medical Benefits in Worker's Comp.

August 17, 1995

Broomfield, Colorado

303-460-9129

American Management Association

Complete Guide to OSHA's Healthcare Standards & regulations

August 21, 22, 1995

Denver, Colorado

800-821-3919

American Association of Blood Banks

Ensuring a Predictable Donor Base: Marketing Models

for the 21st Century

September 10-12, 1995

Hyatt Regency Denver, Denver, CO.

Contact: (303) 295-1234

Colorado Hospital Association

70th Annual Meeting—Transition Through Trust

September 13-15, 1995

Vail, Colorado

303-758-1630

American Society for Medical Technology

Intermountain States Seminar, "Renewal of Excellence".

September, 13-16, 1995

Jackson, Wyoming

Contact: Mary L. Minish, IMSS Publicity Chair, P.O. Box 3778, Jackson, WY. 83001

Commission on Family Medicine

1995 Opportunities Fair, "Your chance to recruit physicians from the ten Colorado Family Residency training programs.

September 22-24, 1995

Copper Mountain Resort

Contact: (303)745-4275

American Medical Association

The 1995 Political Education Grassroots Conference

September 27-28, 1995

The Mayflower Hotel•Washington, D.C.

Contact: Department of Registration Services- 1-800-621-8335

Denver Medical Library

Third Annual Medical Informatics Fair

September 28-29, 1995.

1719 E. 19th Street, Denver, CO

Contact: The Denver Medical Library at (303) 839-6670

American College of Cardiology

Enhancing Quality and Value in Cardiovascular Care

September 28-30, 1995

Keystone, Colorado

800-257-4739

Fall Clinics of Montrose, Colorado

24th Annual Montrose Fall Clinics

September 29-30, 1995

Contact: Kathy Holman (303)-240-7397



David C. Martz, MD
President, 1994-1995

"Fish. . . . or be bait? We've been too long on the wrong end of the pole."

CPN is up and running. It is a reality at last! Now, it's time to get to work.

That seems a strange thing to say, after so many of our members worked so hard to get CPN put together and bring it to fruition. We had the frustrating days of "mandatory" versus "voluntary" participation, the added physical and fiscal expense of rebating those who didn't wish to stay in and sorting out those who did in a manner that no one was misled as to what they were investing in. And then, the long hours of interviewing and reviewing the candidates for partnership in this program to help all Colorado patients and physicians. But it is now all behind us, and time to "Fish . . . or BE bait!"

Over the past few years, physician vocabularies have acquired new words of terror: "downsizing", "rightsizing", and "disaffiliation", to name just a few. Both patients and doctors have grown to fear the loss of choice in physician-patient relationship. Clerks and red tape have replaced or strangled medical decision-making. We were convinced that this is not the way medical practice should be. But to change that lot in life was not simple; it would take some massive effort like a statewide network of physicians to be able to change that picture.

We've Done It!

That's right, we have accomplished the feat that so many said was impossible, and so many others said was too late. Our timing turns out to be near perfect, because we have been able to bring into our partnership one of the most successful HMOs in the United States: Rocky Mountain HMO, the physician-friendly Western Slope health plan that has 20 years experience operating a program that puts patients first, and provides each physician with control over medical decisions.

Rocky Mountain HMO now serves 67,000 members statewide. The organization has been unique in that it has removed so much of the financial baggage from the doctor's office, allowing the physician to concentrate on treatment, cutting costs to the patient and the insurer.

While primarily known for its successes on the Western Slope, its coverage is spread over 20 counties, including metropolitan Denver and Boulder. We look forward to working with this outstanding group of professionals.

Where do you come in?

Which end of the pole do you want to be on, the reel end or the hook end? Fish. . . or end up as bait. We've been too long on the wrong end of the pole.

By now, every member of Colorado Medical Society has received my letter announcing this collaboration, emphasizing that this arrangement will provide equal coverage for rural and urban physicians and patients.

During the next two months, the CPN Board and Rocky Mountain HMO will be formulating the detailed business plan. A special forum will be held at the CMS Annual Meeting, September 8-10. Informational meetings will be held in your practice community to spell out the details of implementation, and you'll be contacted personally in the next three months with details of participation.

We hope to complete empanelment of the physician network by November and have the product on the market by early 1996.

Let's Implement!

As we move into the implementation phase of CPN, I want to express my gratitude to those who have made this possible from the visionary leaders of the past three years to the CMS members who endorsed the concept with their financial and/or personal support.

Now we all have the opportunity to mold our professional destiny by moving back to physician-driven health care. It is time for each of us to choose:

"Shall we fish . . . or be bait?"

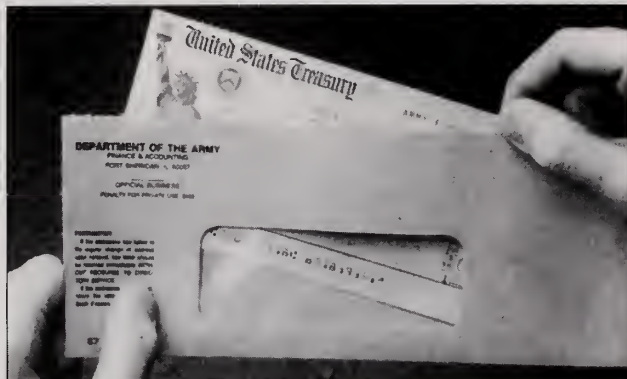
Colorado Physician Network Forum

Date: Friday, Sept. 8, 1995
Time: 1:15 to 2:15 pm at the CMS Annual Meeting in Aspen

Providing you with the most current information on CPN/Rocky Mountain HMO venture and product development.

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LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
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Scheduling trial testimony is very difficult and is often out of the hands of attorneys. Most times, attorneys schedule professional witnesses first thing in the morning or afternoon. This allows them to get the doctor or other professional on and off quickly with a minimum of wasted waiting time. Request those time slots, if possible. Courts usually will accommodate the busy professional expert witness by allowing him or her to be called out of order.

Review of all of your records, test results and radiological studies. Compare radiological studies taken at different times. Ask the attorney or patient for all records, test results and radiological studies that exist from before and after the accident in question. The more prepared and knowledgeable you are the better witness you make.

Read all other doctors' assessments of your patient. Do not advocate a position for your patient, as this is painfully obvious to a jury. Professionally prepare and

testify, be objective and straightforward. There is no right answer. There is only your answer based on your objective, professionally-reasoned opinion.

It is important to meet with and prepare for your testimony with the attorney utilizing your services. This can assist you in knowing the areas that are at issue and will also let you know exactly what to prepare for. Professional studies or research concerning an area of testimony can only enhance the strength of your opinion. If there are studies, advise the attorney so the research can be endorsed and used at trial.

Work out all payment arrangements in advance. Get paid before you testify. The attorney requesting your testimony should pay for your preparation time, travel time (portal to portal), and testimony time. Confirm all agreements in writing.

For further information please contact:
A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling, P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society

The "Executive Director's Update" seems to be a misnomer at times, but this month in particular. I don't feel as though I am the executive (#1 banana or in charge), nor do I feel as though I have been directing anything. Life in the medical lanes is so incomparably fast that I don't think any one person can be in charge of anything, much less direct it. June and July at CMS are fine examples.

We came back from the AMA Annual Meeting and immediately plunged into getting ready for our own Annual Meeting (AM), but prior to that we have several major issues, each having developed a life of its own, which have to come to a head before the AM.

1. Colorado Physicians Network which, as you have seen, has just reached a boil and now must be turned down to a controllable simmer as we start to fold in the cream of the physicians who want to participate.
2. A resolution from the Board of Directors to create a University faculty component of the Colorado Medical Society is in the oven and requires minute-to-minute watching. This one has been on slow bake for some years, and is brought to a browning temperature every once in a while. This year, I think we can actually get the solution to rise into a workable "town-gown" coalition, but it's going to take a lot of effort. There are a lot of cooks in the kitchen with us.
3. Preparation for the new legislative year (which starts well before the General Assembly reconvenes in

January) is being stirred like a giant pot of alphabet soup. There 's a number of major medical bills on the table which must be mixed into workable legislative proposals, carried out to the lawmakers for sponsor-commitment (tasting) and sitting down to compromise discussion before they are ever ladled into the bowl (put into the final form of "A Bill").

4. Workers Compensation looks to be taking a turn, following a rulemaking hearing on July 20th. I don't know the outcome of this hearing, as I write this, but I do know that the talk is of new legislation concerning Workers Comp fee schedules, etc., in the coming year. This one reminds me of an inept fry cook trying to toss flapjacks. . . you know, when they come down in the wrong spot, or on the wrong side, or maybe even miss the griddle altogether. I realize that many of you have never touched a Workers Comp case in your entire life, and don't expect to; but let me remind you that, whatever happens, any fee schedule legislation can have a decided ripple (more like a wave) effect on **ALL** of medical practice.
5. Nothing happened in the last session on HB 1262, the "point of service" proposal from Colorado Medical Society. We have to expect that something is going to happen along those lines in the coming year, and we have to be preparing for it. Our preparations might even go so far as to "cook up" an initiated referendum for the November ballot, and if that happens that is a big job.



6. Medicare! Need I say more? Well, in case the point escapes you, read Dr. Robert McCartney's "AMA Update" in this issue. We not only face more tinkering with Medicare ingredients, but we are now challenged by the double-whammy of a "new Medicare" and a Republican-wrought "New America". I'm not saying either idea is a bad one; you see, there's no proven, workable recipe for either one: Medicare revisions OR the Republican's New America. You remember "Little Jack Horner . . . sat in the corner eating some curds and whey. Along came a spider, sat down beside her (?), and said 'Horner, you ought to take this plan and go 'way! I've got a new philosophy that'll really whet their appetite.'"

Well, there you have it. Numerous new developments under way at CMS, and most of them inspired by a spirit of pro-activeness. All are issues about which every CMS member should be well informed and have a voice. Do you feel as though you've read an update, or is "update" also a misnomer? Things are happening so fast any more that it's difficult to do an update; can't get that far ahead. Maybe we ought to call it "Executive Director's Warning".

THE LOBBY



Richard Allen, MD
Chairman, CMS Council on Legislation

120 Days Plus!

"The mood of the country is still definitely on our side. . ."

I hope you all had a chance last month to read the **"120 Day Newsletter,"** each year's legislative wrap-up, particularly the article which painted a fairly successful year at the capitol for the Colorado Medical Society. However, one of the points I stressed in the **"120 Day Newsletter"** is that our job does not end with the Legislative *sine die*, but rather just begins in terms of planning for the next session.

There are basically two simultaneous, ongoing summer activities which are equally important. First is the continued interaction with the

legislators on a personal basis and the strengthening of our key contact program in which all of you are not only invited but encouraged to participate. For those of you who find it onerous to interact with your legislator, a minimum activity would be to send your dues in to COMPAC so at least we have the funds to do your lobbying for you.

The second summer activity is the development of legislative issues which we will pursue in the next session.



The sooner we have proposed legislation ready to enlist sponsors, the more success we will have in passing our legislation. Toward that end, we have picked November 15 as a bottom line for having legislation ready to go.

There is a third summer pursuit - monitoring the activities of others which may have an impact on us. For example, there are a number of alternative care providers whose Sunset review comes up this next year and we are monitoring what they are doing to be sure it is not counter to our role as physicians. An example of this involves several meetings we have had with Board of

Pharmacy representatives who wish to pursue an expanded scope of their practice.

This is similar to the issue we faced last year with the Nurse Practice Act. The pharmacists, however, have made it clear that they are not asking for independent prescribing privileges, but rather privileges in a collaborative setting.

Part of what they feel is the pharmacist's role is to establish protocols to initiate therapy. Members of the Council of Legislation have found this difficult to accept. We will continue to monitor their activities to see exactly what they are asking for and how involved we may wish to become, if at all.

The Rural Health Task Force has continued to meet throughout July and the subcommittee to draft legislation has now provided a draft bill which is circulating to various interested parties for their input. It is stressed that this is still just a draft document, but I feel confident that by the September House of Delegates we will have a draft bill. We have a number of interested sponsors in the legislature and I feel we will easily make the November deadline for getting this bill introduced.

During June and July we've had several meetings with what we are referring to as the "Business Working Group Coalition" (until we can come up with a better name). These meetings are continuing. This is basically a leadership group from business and insurance industries and CMS, to see if we can agree on

(Continued on following page)

THE LOBBY (Continued)

some common goals for patient access of medical and health care and can collaborate on a bill. Any bill that would have both business and physician support would be a major step forward. The talks thus far have been cordial and productive and we do feel that we have a great deal of common ground.

The mood of the country is still definitely on our side and a number of states have passed versions of the AMA's Patient Protection Act. We are currently looking at the successful legislation passed in Oregon and may very well may try to modify this for Colorado needs. At the recent AMA House of Delegates in Chicago, our "white paper" with the HMO Association regarding affiliation/disaffiliation issues attracted a great deal of interest from all of the delegates throughout the country. In this regard, Colorado is assuming a

leadership role. (You may also wish to read the article in this issue of *Colorado Medicine* by AMA Alternate Delegate Robert McCartney regarding national efforts to reform Medicare and Medicaid.

There are a number of other issues looming on the horizon; for example - proposed changes in the Worker's Compensation payment schedule, and Sunset reviews for respiratory therapists, occupational therapists, hemodialysis therapists, athletic trainers, and direct entry midwives. As you can see, it has been a busy summer with no letup and your Council on Legislation leadership are working hard on your interests.

As always, we solicit your ideas and support and, once again, hope that you will support us and the rest of your colleagues by becoming a member of COMPAC to help us accomplish our goals. I will certainly be happy to speak with any and all of you at the annual meeting/House of Delegates in September.

K. Mason Howard, MD lauded by CMS Board for accomplishments in organized medicine



Dr. K. Mason Howard (r) listens intently as CMS President Dr. David Martz reads from the plaque presented Dr. Howard for his services to CMS, Copic Insurance and his profession.

After nearly 13 years devoted entirely to building one of the nation's most successful professional liability insurance companies, Dr. K. Mason Howard retired from his CEO position December 31, 1994. He was the original CEO for Copic Trust and for Copic Insurance Company, which followed.

At its July meeting, the CMS Board recognized Dr. Howard for his many accomplishments on behalf of his fellow physicians, noting his service on the Claims Committee in the 70's his presidency of CMS in 1980-81, and his long tenure with Copic.

Dr. Howard is now working on a part-time basis on a number of projects for Copic, and is officed with Copic Board member and legal counsel, George Dikeou. Though he formally retired from Copic in December, K. Mason has not given a specific date on which he will quit work entirely. He has mentioned that he and his wife will be traveling, but neither has divulged any specific plans yet.

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without a scorecard."**

and **THE** scorecard is
the twice-monthly newsletter

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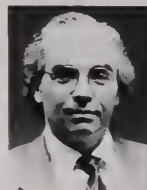
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HCCA, 655 Broadway, Denver, CO 80203.

R eorganization of CMS

by Mark Levine, MD
Chairman, OSC Task Force



"... physician groups who have not traditionally been active in Colorado Medical Society."

Geographic medical societies have been the traditional cornerstone of the organization of CMS. Yet it is unclear that this is the organizational structure that will move Colorado Medical Society into the future in the most appropriate manner.

Other states have experienced considerable difficulty in statewide physician organizations as the geographic orientation of component medical societies has at times been interpreted as excluding certain physician groups who do not orient to the geographic society.

For instance, Nevada has seen a competing medical society of managed care physicians evolve as the managed care physicians had apparently perceived that the geographic based medical societies were not being responsive to managed care needs.

Colorado Medical Society is beginning to address these issues through a task force that has been brought about through the recommendation of the Organizational Study Committee. This task force is looking at new organizational structures for CMS that could more effectively meet the needs of Colorado's physicians for the next decade. Through this process we hope to find ways to reach out to physician groups who have not traditionally been active in Colorado Medical Society, including academic physicians, and physicians in medical groups and managed care organizations.

The task force has met twice and has recommended that CMS con-

sider the evolution of a component society of University physicians which could relate directly to CMS without going through a geographic medical society in addition. This approach is not without its problems as it sets a precedent which may be uncomfortable for geographic medical societies and does not answer all questions regarding how other groups of physicians should orient to CMS.

CMS has agreed to sponsor a process of reaching out to non-CMS physician leaders to attempt to understand what these physicians would perceive as the need for a statewide physician organization. That input will be brought back to the task force with the idea in mind of eventually suggesting a long term structure for the Colorado Medical Society that would enable us to understand the role of geographic medical societies and other potential components through which the physicians of Colorado can relate to CMS.

The task force will present an update to the Annual Meeting of the Colorado Medical Society in Aspen in September and solicits the input of any interested CMS member who would have constructive suggestions for how to approach this.

Vaccines For Children (VFC) program implementation in Colorado



By Judy Conner, Director
Immunization Program
Colorado Department of Public Health & Environment

The goal of the federal Vaccines for Children (VFC) program — authorized by the Omnibus Budget Reconciliation Act (OBRA) of 1993 — is to help raise childhood immunization levels in the United States by supplying federally-purchased vaccines to participating private and public health care providers. This vaccine may be administered by private providers to children who are ages 0-18 years who are uninsured, Medicaid-enrolled, or American Indians/Native Alaskans. Additionally, children whose insurance does not pay for immunizations may receive VFC vaccine at federally-qualified health centers (FQHC's) and may also be immunized at public health agencies in Colorado. The VFC program was slated to begin nationwide on October 1, 1994. On that date, the program was fully operational in Colorado's public, rural and migrant health clinics, as well as in community, Indian, and neighborhood health centers and health centers for the homeless.

Colorado was one of 25 states planning to use the national vaccine distribution warehouse originally established by VFC legislation for the purpose of dispensing vaccines to private physicians. Enrollment of private practices into the VFC program began in May, 1994 so that the program could begin by the October 1994 target date. Congress however, abolished the warehouse plan just weeks before the scheduled implementation date. Following this congressional action, the National Immunization Program, Centers for Disease Control and Prevention

(CDC) began negotiations with vaccine manufacturers to distribute VFC vaccine directly to private physicians.

In April, 1995 because CDC had not made significant progress on their plan for manufactures to deliver the vaccine, they canceled those negotiations. Therefore, the Colorado Department of Public Health and Environment's Immunization Program began expanding vaccine storage and delivery capacity to include vaccine shipments to VFC-enrolled private medical providers. It is anticipated that this expanded system will be in place no later than January 1, 1996.

Private provider enrollment in VFC

A total of 253 private provider sites in Colorado, representing nearly 700 individual physicians, have already enrolled in the VFC by submitting the one-page Provider Profile and the one-page Provider Enrollment forms which are required by OBRA. These sites have received materials necessary to order VFC vaccine and to screen children for VFC eligibility. (See box for additional information & ordering.)

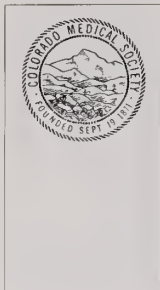
Special Note For Private Medicaid Providers

Until such time as the VFC program is operational for the private medical community, physicians in Colorado may continue to obtain vaccines through the Infant Immunization Program, a VFC-like program established in 1992 by the

"... nearly 700 individual physicians, have already enrolled in the VFC ..."

The Immunization Program has VFC information and enrollment materials available and will mail them to physicians or groups who have not yet enrolled in the VFC program. For specific VFC information or additional materials, contact:

Jackie Murray
Infant Immunization
and VFC Programs
Colorado Dept.. of Public Health
and Environment
4300 Cherry Creek Drive South
Denver, CO 80222-1530
(303) 692-2798



by Robert D. McCartney, MD
AMA Alternate Delegate

Doctors, patients, Medicare and Republicans

1995 is the 30th anniversary of the enactment of Medicare, the most sweeping health care bill ever passed by the United States Congress. It has also been the most successful health care program, clearly meeting its objective of providing the older American with access to high quality, comprehensive health care. Additionally, it had been predicted from the beginning that the program would become unaffordable for the US taxpayers. This reality has been stalled for the past 25 years. Today, we must face the reality and decide how the program can serve the population, seniors and doctors in the future.

The Colorado AMA Delegation had the opportunity in Chicago on June 19, 1995, to listen and interact with Speaker of the House, Newt Gingrich, as he outlined the Republican agenda for the transformation of Medicare and of America.

Initially in 1965, customary, prevailing and reasonable (CPR) was adopted to keep Medical payments competitive with the private sector, thereby encouraging physicians to participate and see patients. By 1973, it was apparent that the rate of growth of the program needed to be curbed. In that year the **Medicare Economic Index**, a cap on the annual update of the Medicare fee schedule based upon a percentage of the fees in the base year, 1972, was instituted. Still, problems existed. The program continued to grow and remain increasingly expensive. The reimbursement mechanism rewarded the use of high technology, while underpaying for

evaluation and management services, the so-called cognitive services. Additionally, because of historical trends, urban health services were valued greater than services rendered in the urban setting.

In 1989, in an effort to address the inequities of the physician reimbursement system, Congress enacted the Resource Based Relative Value Scales (RBRVS), which when combined with a conversion factor determined annually by Congress, would create a fee schedule. However, at the same time, OBRA of 1989 also introduced several features designed to limit the costs of the program, the Volume Performance Standards (VPS), one for surgical and another for nonsurgical services. A floor was set below which the VPS could not lower the Medicare Economic Index. Limits on physician billing above the Medicare approved reimbursement were created. A formula was devised to rationalize the geographic variation in Medicare reimbursement to physicians in different regions of the country.

The final version of the RBRVS became very politicized as various medical specialties jockeyed to have key relative values readjusted. The initial performance of physicians under the VPS moved to actually worsen the plight of primary care physicians. It was found to be difficult to find reliable measures to accurately adjust the regional variations in reimbursement. As a result, OBRA of 1993 made further adjustments to the formula. A separate, and third, VPS was created

for primary care. However, Congress also lowered the floor by which the Medicare Economic Index (MEI) could be adjusted, and the volume standard reduction factor, a measure based upon the VPS used to lower the MEI, was increased from 2% to 4%. The net result was that despite the intent to protect primary care services through a separate VPS, the altered methodology offset any potential gains.

Dissatisfaction with Medicare reimbursement among physicians heightened. Budgetary fixes, such as arbitrary spending caps and provider payment reductions, have not worked.

Politically, however Medicare is ripe for funding reductions. Medicare represents the fourth largest budget item. In 1994, the largest budget items included:

Social Security	\$321 billion
Defense	\$277 billion
Interest on debt	\$212 billion
Medicare	\$147 billion
Medicaid	\$92 billion

Between 1981 and 1993 the cumulative cuts to Medicare amounted to only \$98 billion, a small amount compared to other government programs. OBRA of 1990 imposed a reduction of \$32.9 billion over five years; OBRA of 1993 imposed another \$55.8 billion over 7 years. Speculations of proposed cuts for 1995 range between \$250 - 300 billion over the next seven years. Cumulatively, this could, considering inflation, amount

(Continued)

Doctors, patients, Medicare and Republicans

(Continued from preceding page)

to as much as a 36% reduction in physician payments. This would create a barrier to access for America's elderly as physicians begin to limit the numbers of seniors for whom they could care.

Political realities, however, are that the Medicaid Part A Trust Fund, funded by payroll deductions, hospitalization deductions and copayments, is not actuarially sound, and is projected to be bankrupt by 2001.

Medicare Part B is to be funded 25% by beneficiary premiums, and 75% by general revenues; general revenue is becoming a larger portion of the funding as premiums fail to cover the necessary portion. Part B is growing rapidly, with projections for 2000 seen to double that of 1994.

The most rapidly growing components of Part B are outpatient hospital facilities, independent laboratories and home health services.

Physician services are not a major component of the rapid growth. Without change Part B expenditures will exceed Part A by 2015. Without policy change, Medicare, Social Security, and Federal Retirement will consume the entire budget by 2030.

Representative Gingrich (R, GA.) addressed the AMA telling us that the "New Vision of Health for America" included considerations of Medicare, Medicaid, the Veterans Administration the free market and the exportation of technology and pharmaceuticals in the foreign market. Viewed optimistically, health care can become an opportunity instead of the traditionally viewed problem. This opportunity is reflected in the preference by the whole world for access to the American health care system.

Mr. Gingrich envisions that care delivery would occur through a variety of options, including Medical Savings Accounts, coordinated care, fee-for-service care, vouchers, and

increased participation by wealthy seniors in funding their own care. Through choice and options, the elderly American can become a customer of the health system, rather than a captive. He stated that physicians could be spared payment cuts through savings to the system through tort reform, decreased complexity and hassle, and new efficiencies.

He stated the Republicans would use an open door strategy engaging people, including the AMA, in the dialogue and process, as opposed to the "closed door strategy" used in the 1994 attempt at health system reform. The desired result is to develop a partnership with Americans, moving away from the welfare state.

America, in moving from a welfare state, would become an opportunity society. In achieving this, we would all need to address

- One civilization, multi-ethnic, but unified
- The world market
- The Information Age

The barriers that keep us in the welfare state are drugs, violence and alcohol, all of which must continue to be targets. The strategies which would move the Republican platform forward include:

- Decentralization of the government away from Washington
- Decrease the federal bureaucracy, and benchmark that which remains for excellence
- Balance the budget, and in doing so create reliable trust funds for both Medicare and Medicaid
- Ensure safety through decreasing violence and the drug trade
- Lead the planet in marketing our technology

Your AMA has looked at these issues, including the possible Republican actions, very critically. Your AMA's proposal includes two strategies:

- Medicare is an open-ended promise, limited neither by spending nor by financial need. This promise must be restructured.
- Coverage and benefits must also be addressed

Five categories of action are

proposed:

- There must be **enhanced personal responsibility and awareness of cost** at the time of purchase. Medigap supplemental policies inhibit this cost awareness. The Congressional Budget Office has estimated that beneficiaries with Medigap policies consume 24% more health care. AMA suggests that the first \$1200 of out-of-pocket expense not be reimbursed by Medigap policies. Additionally Medical Savings Accounts, a method for saving dollars for health purchases in a tax deferred account, and vouchers, used to purchase private health coverage, are other measures to increase cost awareness.
- **Inter-generational equity** must be enhanced. Today's workers are funding the care received by today's beneficiaries. Currently four workers must pay for the expenses of one senior. In the near future, this will be reduced to two workers per beneficiary. This unfair burden translates to higher taxes and fewer opportunities for America's youth. AMA suggestions again include Medical Savings Accounts, increased Part B premiums for wealthy seniors, and raising the age of eligibility for Medicare above 65.
- Health care providers should be able to **compete on price**. This could be accomplished by allowing health systems to compete, based on the Part B conversion factor and Part A DRGs.
- Reduced regulatory and administrative complexity.
- Reduced inappropriate and wasteful care. As physicians, we can reduce marginal "low-yield" care and futile care.

Speaker Gingrich acknowledged the AMA proposals and asked that a partnership for Medicare transformation should include shared sacrifice. Through dialogue and cooperation it is possible to accomplish change while increasing choice and protecting quality.

R e-accreditation



by Richard D. Krugman, MD

Re-Accreditation Process Will Enhance School's Educational Initiatives

The University of Colorado School of Medicine recently underwent a re-accreditation review by a five-member survey team of the Liaison Committee on Medical Education (LCME). The purpose of this process was to determine whether all accreditation standards are being met for our MD degree.

The LCME survey team was made up of peers from around the county and included Harry Beaty, MD, dean, Northwestern University Medical School; Robert McCollister, MD, associate dean, curricular affairs, University of Minnesota Medical School; Robert Wigton, MD, associate dean, graduate medical education, University of Nebraska College of Medicine; Phyllis Guze, MD, dean for education, UCLA School of Medicine, and Stephen Smith, MD, associate dean for educational affairs, Brown University School of Medicine. The team, which shared its findings with Chancellor Vincent Fulginiti, MD, and me, will prepare a draft report that will be reviewed and finalized by the LCME at an October, 1995 meeting.

A project of this magnitude cannot happen without the ongoing collaborative efforts of many people. The School's Self-Study effort involved four major committees, 15 subcommittees and more than 50 faculty, students, alumni, community physicians and administrators. A group of senior faculty members reviewed the final draft of the self study prior to its submission to LCME.

The LCME survey team process involved a series of meetings with multiple officials responsible for curricular issues, student services and academic leadership. It was conducted in conjunction with a comprehensive data base that had been compiled by the School and the self-study report. The survey team's findings included noted the following major strengths of the School:

- The School is blessed with outstanding faculty, students and deans.
- It has seen progress in its facilities since the last site visit, such as the Biomedical Research Building; a new parking structure, and plans for an ambulatory care facility and a campus center.
- The generalist initiative provides a focus and vision to new programs at the School.
- University Physicians, Inc., the faculty practice plan, has seen significant improvement over the past several years in its management and in its efforts to work within a volatile market place.
- The School has the support of the senior administrative officers of its teaching hospitals, including Uni-

versity Hospital, Colorado Psychiatric Hospital, The Children's Hospital, Denver General Hospital, National Jewish Center for Immunology and Respiratory Medicine, and the Veterans Administration Denver Medical Center.

- After a period of rapid turnover of CU medical school deans, we seem to have moved in the direction of more stability. This has provided the opportunity to implement positive changes.

The team also identified areas where the School needs improvement. These included a need for better facilities, improved service from the Office of Financial Aid, better minority student and faculty recruitment and retention, uniform course and clerkship evaluations, and additional support for an understaffed dean's office.

Together, the self-study report and the external review provided an extensive and important process for the School as it implements major educational initiatives. At the bottom line, we are reminded that our medical students consume the educational product we provide across all departments. If there are inconsistencies in our offering, the outcomes are felt by the students.

The reinforcement of our strengths and weaknesses will help us move forward to become even better educators in the next century.

(Richard Krugman, MD, is a pediatrician, internationally-known child abuse expert and dean of the CU School of Medicine.)



Sandra L. Maloney
Executive Director
Colorado Medical Society

"Who's On First?"



Abbott and Costello, though not CMS members, accurately described the current state of the business of medicine. Just when you think you've got it figured out, someone changes the rules... again. We've structured the activities at this year's Annual Meeting to be your program and scorecard for the 90'S and beyond. Find out who the players are in our 1995 Educational Program, "Who's On First?".

Everything the CMS staff, Councils, Committees and Task Forces do is determined by resolutions presented at the meetings of the House of Delegates. Not only that, but each member has an equal opportunity to present resolutions for consideration, to testify before a Reference Committee (or even serve on one) and to have a dramatic impact on the direction CMS will take on important issues in the coming year. The Colorado Medical Society really *is* a member driven organization.

We have lots of educational and fun activities scheduled for you this year, in addition to the business meetings that set CMS policy and drive all our activities for the year.

Look over the enclosed information, select those activities and meetings in which you would like to participate and fill in your registration form. You then may mail it to us (at PO Box 17550, Denver, CO 80217-0550), phone it to us (at 303/779-5455 or 1-800-654-5653) or even FAX it to us (at 303/771-8657).

Get your registration in quickly. There are limited spaces available for some programs. Notice also that you will need tickets for all meal functions. We must remain fiscally responsible by getting an accurate count of those who will attend these functions.

I encourage you to put on your baseball duds for the reception on Thursday and join us for "Puttin' on the Ritz" at the President's Dinner Dance on Saturday. I look forward to seeing you in Aspen!

Sandra L. Maloney

COLORADO MEDICAL SOCIETY AND COLORADO MEDICAL SOCIETY ALLIANCE

1995 Annual Meeting Line Up

Ritz Carlton Aspen
September 7-10, 1995

THURSDAY, SEPT. 7

8:00 am ---	CMS Office open
11:30 am --- 1:00 pm	Finance Committee
12:48 pm ---	18 hole Golf Tournament
1:00 pm --- 5:00 pm	Board of Directors
4:30 pm --- 8:00 pm	Registration open
6:00 pm --- 7:30 pm	"Batter Up" Reception
7:30 pm ---	Dinner on your own

NOTE: Dress for Annual Meeting

Thursday evening reception: ... baseball attire or casual
Friday: casual
Saturday morning: casual
Saturday inaugural
dinner/dance: black tie preferred
Sunday: casual

FRIDAY, SEPT. 8

7:00 am ---	CMS Office opens
7:00 am --- 5:00 pm	Registration
7:00 am --- 8:30 am	El Paso County Caucus
7:15 am --- 8:00 am	Reference Committee Breakfast
8:00 am --- 12:00 N	Exhibits open
8:00 am --- 8:15 am	Credentials Committee
8:30 am --- 9:30 am	Alliance Board Breakfast
8:15 am --- 8:45 am	Opening Session House of Delegates
8:45 am --- 11:45 am	General Membership Meeting
9:45 am --- 11:45 am	Alliance General Meeting
9:45 am --- 10:15 am	Coffee break
12:15 pm --- 1:45 pm	COMPAC/CMSA Luncheon
1:15 pm --- 2:15 pm	Colorado Physician Network Forum
2:30 pm --- 4:30 pm	Reference Committee on Board of Directors/Constitution & Bylaws/Credentials
2:00 pm --- 3:00 pm	Alliance Workshop
2:00 pm --- 5:00 pm	Army National Guard Physicians
2:15 pm --- 3:15 pm	Copic Risk Management
2:15 pm --- 3:15 pm	Copic Risk Management
3:30 pm --- 5:30 pm	Reference Committee on Health Affairs
3:00 pm --- 4:30 pm	Alliance County Breakout Sessions
3:45 pm --- 4:45 pm	Copic Risk Management
3:45 pm --- 4:45 pm	Copic Risk Management
4:00 pm --- 7:00 pm	Exhibits open
4:30 pm --- 5:30 pm	CMS Alliance Reception
5:30 pm --- 7:00 pm	Exhibitor Reception
6:30 pm --- 7:30 pm	Colorado Society of Internal Medicine Annual Meeting
7:00 pm --- 9:00 pm	Gone But Not Forgotten Dinner

SATURDAY, SEPT. 9

7:00 am ---	CMS Office opens
7:00 am --- 11:00 am	Registration
7:00 am --- 7:50 am	Educational Program Continental Breakfast
7:00 am --- 11:00 am	Exhibits open
8:00 am --- 12:00 N	Educational Program "Who's on First? or What Opportunities Will You Have to Practice Medicine in the Future?"
8:00 am --- 12:00 N	Alliance Meeting - "Unplug the Holiday Machine"
12:00 N ---	Recreation Time: golf, tennis, horseback riding, biking, fishing, walking, etc.
12:30 pm --- 2:00 pm	Women in Medicine Meeting @ the Center for Environmental Studies
2:00 pm --- 3:00 pm	WIM tour @ the Center for Environmental Studies (open to all)
1:00 pm --- 4:00 pm	Copic Workshop-Physician Integration Phase II & Beyond
1:00 pm --- 4:00 pm	Army National Guard Physicians
1:30 pm --- 3:00 pm	Unified Grievance Committee
6:00 pm --- 6:30 pm	Inaugural Address
6:30 pm --- 7:00 pm	Cocktails cash bar
7:00 pm --- 10:30 pm	Presidents' Dinner/Dance
9:30 pm --- 11:00 pm	Copic Dessert Reception

SUNDAY, SEPT. 10

6:30 am ---	Reference Committee Reports available
7:00 am ---	CMS Office opens
7:00 am --- 10:00 am	Registration
7:00 am --- 8:30 am	Component Caucuses
	Arapahoe
	Aurora-Adams
	Boulder
	Clear Creek Valley
	Denver
	El Paso
	Larimer/Weld
	Pueblo/Western Slope
8:00 am --- 8:30 a.m.	Credentials Committee
8:30 am --- 12:00 N	Closing Session HOD
9:00 am --- 10:00 am	CMSA Gavel Club Breakfast
12:00 N ---	or immediately following HOD
12:00 N ---	or immediately following HOD
	Nominating Committee
	Reorganizational Board

Annual Meeting Registration

1995 Annual Meeting of the Colorado Medical Society and CMS Alliance
 September 7-10, 1995, Ritz-Carlton, Aspen, Colorado

Name (please print) _____

Name of Spouse/Guest(s) (if attending) _____

Component Society _____ Office Phone _____

If you are not a member of CMS, please provide the following:

Company/Organization _____ Title _____

Reservations for Events and Meetings

Reservation deadline is August 25, 1995. (Note: To attend the President's Dinner Dance on Saturday, you **must** obtain your tickets before noon, Friday, Sept. 8.) Reservations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders.

As a member, **you and one guest are entitled to attend the complimentary events at no charge.** Please indicate the number of additional guests at the bottom of this form and enclose your check.

Complimentary events open to all members:

THURSDAY, SEPTEMBER 7

6:00 pm Reception: Batter Up! member ☐ guest ☐

FRIDAY, SEPTEMBER 8

5:30 pm Exhibitor Reception member ☐ guest ☐

SATURDAY, SEPTEMBER 9

7:00 am Educational Program Continental Breakfast member ☐ guest ☐

8:00 am Educational Program: Who's on First? member ☐ guest ☐

4:30 pm CMS Alliance Reception member ☐ guest ☐

(for Alliance members & interested spouses)

7:00 pm President's Dinner Dance: **Putting on the Ritz** (Black tie preferred)

(Reservations necessary, please select menu below)

Beef Dinner, or member ☐ guest ☐

Chicken Dinner member ☐ guest ☐

9:30 pm Copic Dessert Reception member ☐ guest ☐

Additional Reservations (other than member + 1 guest):

Reception: Batter Up! # _____ @\$10 each= _____

Educational Program Breakfast # _____ @\$15 each= _____

President's Dinner Dance (Reservations necessary, please select menu below)

Beef Dinner, or # _____ @\$50 each= _____

Chicken Dinner # _____ @\$50 each= _____

..... Total for Additional Reservations \$ _____

Non-Complimentary Events:

Cost

Number

FRIDAY, SEPTEMBER 8

8:30 am CMSA BOD Breakfast \$30 each _____

12 Noon COMPAC/CMSA Luncheon \$25/COMPAC member-\$35/non-COMPAC _____

SATURDAY, SEPTEMBER 9

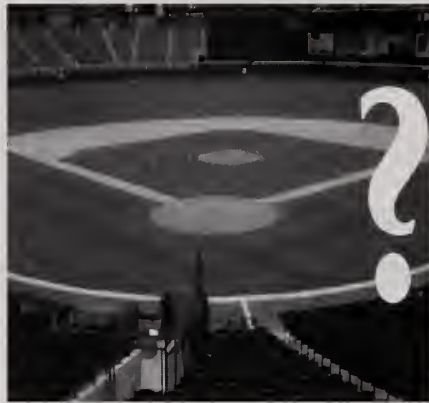
12 Noon Women in Medicine Lunch/Business meeting \$15 each _____

..... Total for Non-Complimentary Reservations \$ _____

Total enclosed for non-complimentary and/or additional reservations \$ _____

After completing this form, please mail it to us (at PO Box 17550, Denver, CO 80217-0550), phone it to us (at 303/779-5455 or 1-800/654-5653) or FAX it to us (at 303/771-8657).

WHO'S ON FIRST?



Colorado Medical Society Annual Meeting Educational Program

Saturday, September 9, 1995

Ritz Carlton, Aspen

Who's on First?

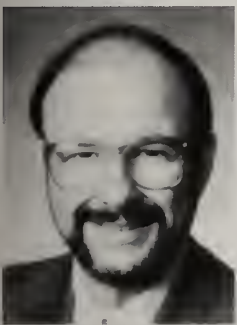
(or What Opportunities Will You Have to Practice Medicine in the Future?)

- | | |
|---------------------|--|
| 8:00 am - 8:10 am | Welcome and Introduction— Joel M. Karlin, MD, CMS |
| 8:10 am - 8:25 am | Overview— Joe Aita, MD, Lifeguard |
| - | Presentations: |
| 8:25 am - 8:45 am | Dick Wright, PhyCor |
| 8:45 am - 9:05 am | David Vandewater, Columbia/HCA |
| 9:05 am - 9:25 am | Mark Donahue, PruCare |
| 9:25 am - 9:45 am | Toby Cole, MD, Kaiser Permanente |
| 9:45 am - 10:05 am | David Ginsberg, Healthcare Consulting |
| 10:05 am - 10:25 am | Break |
| 10:25 am - 10:55 am | Breakout groups headed by each of the presenters so attendees can ask questions in small group setting |
| 10:55 am - 11:25 am | Panel discussion moderated by Dr. Aita—panelists to highlight questions/information from breakouts |
| 11:25 am - 11:55 am | Q&A |
| 11:55 am - 12:00 N | Concluding remarks— Joel M. Karlin, MD |

1995 EDUCATIONAL PROGRAM



S. Joseph Aita, MD



Executive Vice-President and Medical Director, Lifeguard, Inc.

Dr. Joseph Aita, 50, became Lifeguard's full-time Medical Director in

September 1992 and Executive Vice President in March 1993. Aita had previously worked with the 100-doctor Sunnyvale Medical Clinic, since 1974, and helped direct that organization's managed care plans since 1980. As Lifeguard's Medical Director, Dr. Aita's primary focus is working with contracting physicians and hospitals, as well as members and employer groups, to ensure optimal health outcomes.

Dr. Aita has always been an avid proponent of the goals of managed care. Today, in his Lifeguard role as Executive Vice President and Medical Director, he is working with physicians to develop practice guidelines which focus on cost effective ways to achieve optimal health outcomes. The goal of the guidelines is to focus on approaches to health care which have proven benefits.

During his 18 years with the Sunnyvale Medical Clinic, Aita held a number of posts. He was the Associate Medical Director of Managed Care Plans for eight years, a member of the Clinic's board from 1977 to 1979, and from 1983 to

1988, serving as acting Chief Executive Officer and Chairman of the Board during that time, as well. While serving in administrative posts at the clinic, Dr. Aita also maintained a clinical practice.

Dr. Aita joined the Sunnyvale Medical Clinic following two years of service as the Chief of Pediatrics at the U.S. Naval Hospital in Millington, Tennessee. He received his MD degree from Hahnemann University in Philadelphia in 1969. He completed his pediatric training at Duke University and Yale University, and he has served on the Hospital Ship, Hope.

Aita is a Clinical Professor of Pediatrics at Stanford University. He resigned from his medical practice once he became full-time with Lifeguard, but continues as a member of the clinical faculty at Stanford. He is a member of Alpha Omega Alpha, the AMA, the CMA, the Santa Clara County Medical Society and The American College of Physician Executives.

Lifeguard founded in 1977, has over 7,000 doctors, 135,000 enrollees, and over 90 contracting hospitals, as well as a host of ancillary providers in its Northern California network.

David T. Vandewater

David T. Vandewater is Chief Operating Officer of Columbia/HCA Healthcare Corporation. Mr. Vandewater began his career as administrator of Vista Hills Medical Center. He later worked for Horizon Health Corporation, then joined

Republic Health Corporation in 1984, where he held several management positions, including Chief



Operation Officer and Executive Vice President. Mr. Vandewater joined Columbia Hospital Corporation in 1990 as Executive Vice President and was promoted to President and Chief Operating Officer in 1991. He has a master's degree in hospital administration from the University of Houston and a bachelor of science degree from Henderson State College in Arkansas.

Richard D. Wright



Richard D. Wright, Founder, Executive Vice President for Operations and Director of PhyCor, received a BS Degree from

Michigan State University and an M.H.A. from Georgia State University. Military service included three years as a Medical Service Corps officer stationed at March AFB, CA, and Ching Chung Kang, AFB, Taichung, Taiwan. After completion of an administrative residency and one year's employment in Roanoke,

Continued on next page...

VA, he went to Riyadh, Saudi Arabia, in 1975 as the Director, Ambulatory Services, at the KFSH Hospital and HCA-managed hospital. Successive assignments with the HCA International Company included the management of a major consulting assignment in Karachi, Pakistan, and the creation of the Europe-Middle East-Africa Regional Office in London, England. In 1982, he was named as the President of HCA's Americas Region, located in Sao Paulo, Brazil. In this region, Mr. Wright was the Chief Executive Officer of AMICO, a Brazilian HMO with 830,000 subscribers; responsible for Centro Medico Paitilla, a 170-bed hospital in Panama City, Panama; and managed the HCA development effort for Central/South America. In 1986, he returned to the United States to assume the position of Senior Vice President, Business Development for Equicor. With the formation of PhyCor in 1988, he assumed the responsibility of Executive Vice President for Operations.

David A Ginsberg

David A. Ginsberg has been involved in health care consulting and management for over fifteen years. In that time he has assisted numerous physicians and physician groups or organizations in developing strategic plans and operations. His expertise spans both the fee for service and managed care sectors.

Mark Donahue



**Executive
Director of
Prudential
Health Care
Operations**

Mark Donahue has served as the Executive

Director of Prudential Health Care Operations in Denver since 1991.

He graduated from the University of Michigan in 1978. In addition, Donahue completed the Executive Program in Managed Care at the University of Missouri in 1991.

Donahue joined The Prudential in 1982 as a Marketing Representative at PruCare of Illinois. In 1984, he was promoted to Senior Marketing Representative and 1985 was transferred to St. Louis as Director of Marketing.

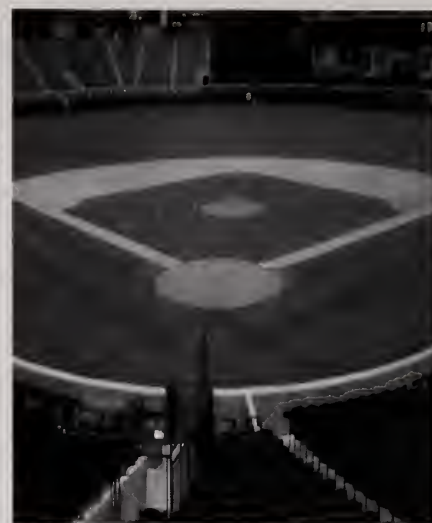
In 1988, Donahue was promoted to a team leader position in the Chicago Office. He was named manager for The Prudential Health Care System of Colorado in 1989 and in 1991 he was promoted to the Executive Director level.

Donahue was recently named President of the Colorado HMO Association and is the recipient of the Denver Business Journal's 1994 Who's Who in Healthcare.

Donahue is married and has two children. He enjoys spending time with his family, skiing and volunteering with his church.

Toby P. Cole

Dr. Toby P. Cole was educated at UCLA, University of California, San Francisco Medical School, Rhode Island Hospital, and Fitzsimons Army Hospital where he finished with training in internal medicine. He worked as a general medical officer and an internist in the USAF and as a staff internist within the Kaiser Permanente system for 15 years. He has managed facilities made up of mostly primary care physicians and for the past 9 years has been the Executive Medical Director of a large multispecialty group in Colorado. He has served on multiple national Kaiser Permanente committees and has current assignment on the National Geriatric Committee of Kaiser Permanente. He serves on the GHAA Quality of Care Subcommittee.



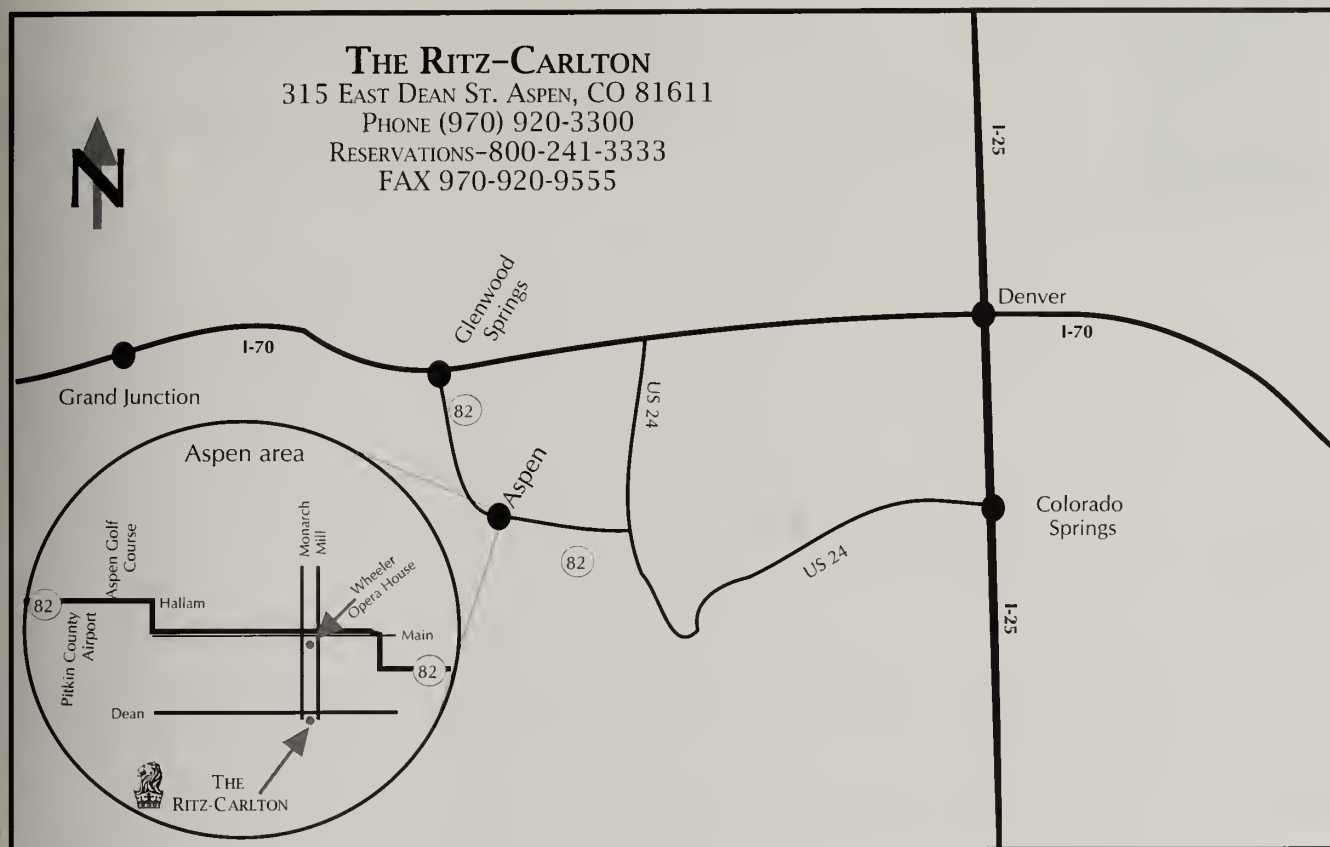
Educational Objectives

After attending this educational activity the physician participants should: 1) Have an increased understanding of different evolving healthcare systems; 2) Be able to distinguish the various structural differences in these systems; 3) Have had the opportunity to address individual needs through direct discussions with individual speakers in break out sessions; and 4) Be able to make improved choices within changing systems in healthcare today.

The Colorado Medical Society is accredited by the Accreditation Council for CME to sponsor continuing medical education for physicians.

The Colorado Medical Society designates this continuing medical education activity for 3 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

This program is sponsored in part by educational grants from the CMS Education and Research Foundation and The Doctors' Company.



**Colorado Medical Society
Annual Meeting
September 7-10, 1995**



THE RITZ-CARLTON
315 EAST DEAN ST. ASPEN, CO 81611
PHONE (970) 920-3300
RESERVATIONS-800-241-3333 • FAX 970-920-9555

Name _____
Address _____
City _____ State _____ Zip Code _____
Phone Number _____ No of Guests _____
Arrival Date _____ at _____ (Check in time is 3:00 pm)
Departure date _____ at _____ (Check out time is 12:00 noon)

☐ \$125 Single or double occupancy
Rates are per room, per night

☐ King Bed ☐ 2 Double Beds
☐ Smoking ☐ Non-Smoking
Rates do not include the room tax currently 11.2%

ADVANCE DEPOSIT REQUIRED TO CONFIRM RESERVATIONS.

Method of payment:

☐ American Express
☐ Diners Club

☐ MasterCard
☐ Carte Blanche

☐ Visa
☐ Check enclosed

Account Number _____ Expiration date _____
Credit cards will be charged at the time the reservation is made.

Signature of Card Holder _____

Deposit: Each reservation must be accompanied by a two-night deposit which will be applied to the first and last night's stay. Deposits are to be received no later than August 18.
Deposits are refundable if reservations are canceled more than 7 days prior to arrival. All deposit money is nonrefundable if a cancellation is made within 7 days of the arrival date.
Reservation Cutoff: Rooms will be held for the attendees of Colorado Medical Society at this special rate until August 18. Reservations received after this date will be accepted on a space available basis at the group rate.

Special requests _____

CMS Annual Meeting Golf Tournament

at Aspen Golf Course
Thursday, September 7, 1995
Entry Form

Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____ Home Phone _____ FAX# _____

(Needed for tee times)

While in Aspen I will be staying at _____

I will be attending the meeting in the capacity of (check one)

☐ Physician

☐ Exhibitor

☐ Spouse

☐ Other

I will:

☐ Sponsor a golf course hole @\$100

☐ Sponsor a putting green contest hole @\$50

Name of sponsor (as you wish it to appear on sign) _____

(Professionally made signs will be displayed for sponsors.)

My golf handicap is _____

☐ USGA

☐ Other

I will require rental clubs @ \$60

☐ Left handed

☐ Right handed

(Big Berthas may be available)

Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference of who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament entry, registration form and advance payment of \$100 must be received **no later than** August 21, 1995. Cancellations received after August 21, 1995 are refundable subject to ability of Aspen Golf Club to "resell" vacated tee times.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at 970-925-2145.

I prefer to be teamed with _____

* Mail Entry Form and check to Media Specialties, P. O. Box 36357, Denver, CO 80236. For additional information, call Tim Jackson at 303-986-5926.



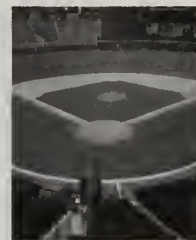
Physician Spouses: Take Note

As always, there are many activities at the Annual Meeting targeted toward you, the spouse of a CMS-member physician. Many of these activities are sponsored or produced by the Colorado Medical Society Alliance. These events are highlighted on the main Annual Meeting Schedule. Please look it over and make plans to attend.

Alliance Reception

One event which did not appear on previous schedules is the CMS Alliance Reception on Friday, September 8 from 4:30 to 5:30 pm. We hope you and your spouse will take time to attend this important function.

Changes in Health Care: Moving into the Second Inning



We have seen the future of health care and it is a lot more organized than the present. IPAs, Groups Without Walls, POs, PHOs, MSOs, practice acquisitions: you received much useful information on these and other changes in medical practice if you attended the educational sessions of the 1994 Annual Meeting in Beaver Creek.

Data collection was the beginning of the process of physician integration. Now you need to know about the business and regulatory aspects of integration models, including the future of physician integration. You need information on keeping your retirement plan viable in the changing scene of health care integration. You need the Physician Integration Seminar to be presented

at this year's annual meeting in Aspen.

Gerald A. Neiderman, an attorney with the firm of Faegre and Benson, will present *Physician Integration: Current Issues and Beyond*, in which he will help you plan your steps as the marketplace moves beyond loosely organized "first generation" contracting groups. This presentation will address tangible issues such as the process of health care integration and provide informed guidance regarding likely future developments.

Leon Harrison, CLU, of the Copic Agency, will tell you about some of the financial aspects of groups, especially retirement in *Beyond Qualified Plans*. In modern health care integration you need to

consider compensation plans, retirement plans, practice valuation in case the merger falls through, and how to avoid becoming famous at the IRS. Mr. Harrison notes that qualified plans are the only assets in America that face triple taxation and an 80% loss to your heirs, however, two of these three taxes can be avoided (he will tell you how). This presentation will also give you some very useful information about very attractive alternatives to qualified plans.

This seminar will be presented on Saturday, September 9 at 1:00 pm, in Aspen, Colorado. It is sponsored by the Copic Insurance Agency. For more information, contact Ron Krieger at 303-779-0044 or 1-800-421-1834.

Balloons Up Your Nose and Other Alternative Medical Breakthroughs

Want to know the real truth about "alternative medicine"? Attend this session. **James A. Lowell, PhD** will be the featured speaker at the COMPAC/CMSA Luncheon during the 1995 Annual Meeting in September.

Dr. Lowell attended Columbia University and then the University of Arizona where he received his PhD with a specialty in genetics. He currently teaches biology and genetics at Pima Community College in Tucson, Arizona.

He serves on various editorial and advisory boards including the board of directors of the National Council Against Health Fraud, the editorial board of Nutrition Forum and the scientific advisory board of

the American Council on Science and Health. He has served on several state task forces dealing with health fraud and acted as a scientific advisor to the US Department of Justice and attorneys general of several states in cases dealing with health fraud.

He is the author of close to 200 journal and popular articles on both health fraud and biological topics. Currently he is completing a CD-ROM on cell chemistry and cell structure which should be on the market later this year.

Register now for the COMPAC/CMSA Luncheon, Friday, September 8 in Aspen. Cost is \$25 for COMPAC members/ \$35 for non-COMPAC members.





CMS ALLIANCE



*Patti Brown, President
Colorado Medical Society Alliance*



STOP AMERICA'S VIOLENCE EVERYWHERE

The American Medical Association Alliance

If you would like more information on how you can help or if you would like to make a contribution to cover the cost of some of our plans, contact:

Sonnie Talley
5690 Green Oaks Drive
Littleton CO 80121
303-795-5719

Patti Brown
6865 W Princeton Ave
Denver CO 80235
303-988-0888

You Can Help Stop America's Violence Everywhere

Physicians are one group of people that don't need to be reminded of the devastating effects of violence on our families, our health care system, and our society. That's why you are invited to help the Alliance SAVE Today... Stop America's Violence Everywhere. On Wednesday, October 11, 1995, the CMS Alliance will take part in a nationwide effort to emphasize grassroots solutions to local problems related to violence. The idea of this program came from the Strategic Planning Task Force of the AMA Alliance. Robert McAfee, MD, immediate Past President of the AMA has agreed to be the national spokesperson. There is a Noon rally planned in Chicago on Monday, October 9, 1995.

Local SAVE plans are currently being formulated. Some of our plans include:

- Bill Ritter, Denver's District Attorney has agreed to be our spokesperson for this event. Plans are for him to appear on talk shows and discuss the problem of violence and some solutions.
- An ad campaign on grocery bags at King Soopers for 2 weeks in October. This ad will list resources available for victims of child abuse, domestic violence, promote the I Can Choose workbook that teaches conflict resolution, promotes The Conflict Center.
- A billboard campaign around the state with a message promoting nonviolence.
- Distribute I Can Choose workbooks to Colorado's school children K-3.
- Articles to newspapers around the state around the nonviolence theme

on varying topics with area resources.

- Encouraging school newspapers around the state to have articles in their papers as well. Encouraging the schools to plan a "Day without violence" on October 11, to use the day to discuss conflict resolution. Turn off the TV for one day, community service projects, etc.
- TV coverage.
- A poster campaign in emergency rooms and other areas encouraging citizens to SAVE Today for Tomorrow with statewide resources if they are victims of violence or where to go to learn conflict resolution or who to contact to learn violence alternatives.
- We are working with the Colorado Domestic Violence Coalition, The Conflict Center, area schools, and area shelters to devise other activities.
- The governor has agreed to sign a proclamation declaring the second Wednesday of October as SAVE Today and to acknowledge the Alliance's long standing commitment to ending violence and helping its victims.

I hope the Medical Society will agree to join with us in making October 11, 1995 a day without violence in Colorado. Your considerable talent and resources will be greatly appreciated in developing a program that truly Stops America's Violence Everywhere!

Thanks

Patti Brown



Check up on Alamo's member benefits.

As a member you can receive great savings from Alamo. Now through December 13, 1995 you can save \$30 OFF AN UPGRADE and \$10 OFF in the U.S.A. or 5% OFF in Europe*. Plus, there is no charge for additional drivers.

Alamo has over 115 locations in the U.S.A. and 34 locations in Europe (the United Kingdom, Switzerland, Republic of Ireland, The Netherlands, Germany, and Belgium). And don't forget we offer *unlimited free mileage*, every day at every location.

In addition, you can receive airline frequent flyer benefits with Alaska, American, Delta, Hawaiian, Northwest, United and USAir. And you'll get Hyatt Gold Passport or Hilton HHonors bonus points when your Alamo car rental is in conjunction with a qualifying stay.

For reservations, call your Professional Travel Agent or call Alamo at 1-800-354-2322. Be sure to request I.D. # **93238** and Rate Code **BY**.



Where all the miles are free*

Alamo features fine General Motors cars like this Buick Regal.

39729AS-B

\$30 OFF AN UPGRADE

- Certificate is valid for \$30 OFF AN UPGRADE (not valid on time and mileage). Upgrade subject to availability at time of rental, as certain car types may not be available.
- Valid from an economy car and above. The maximum value of this certificate which may be applied toward upgrade charges is \$30 OFF (not valid on time and mileage). No refund will be given on any unused portion of this certificate. Certificate is not redeemable for cash.
- Offer valid on rentals of 2 to 14 days.
- Only one certificate per rental, not to be used in conjunction with any other certificates/offers.
- A 24-hour advance reservation is required. Reservations are subject to availability at time of booking.
- Certificate must be presented at the Alamo counter on arrival.
- This certificate is redeemable at all Alamo locations in the U.S.A. only. Once redeemed, this certificate is void.
- This certificate and the car rental pursuant to it are subject to Alamo's conditions at the time of rental. Minimum age for rental is 21. All renters must have a valid driver's license.
- Certificate does not include any taxes or other optional items.
- This certificate is null and void if altered, revised or duplicated in any way. In the event of loss or expiration, certificate will not be replaced.
- Certificate cannot be used in conjunction with an Alamo Express PlusSM rental.
- Offer valid through December 13, 1995 except: 11/23/94 - 11/25/94, 12/15/94 - 01/01/95, 02/16/95 - 02/18/95, 04/13/95 - 04/15/95, 05/25/95 - 05/27/95, 06/29/95 - 07/08/95, 07/21/95 - 08/19/95, 08/31/95 - 09/02/95, 10/05/95 - 10/07/95 and 11/22/95 - 11/25/95.

\$10 OFF IN THE U.S.A. OR 5% OFF IN EUROPE*

- Certificate is valid for \$10 OFF in the U.S.A. or 5% OFF in Europe*.
- In the U.S.A., valid from a compact through a fullsize car. In Europe*, valid on an economy through a fullsize car with manual transmission.
- Offer valid on rentals of 5 to 14 days.
- Only one certificate per rental, not to be used in conjunction with any other certificates/offers.
- A 24-hour advance reservation is required. Reservations are subject to availability at time of booking.
- Certificate must be presented at the Alamo counter on arrival.
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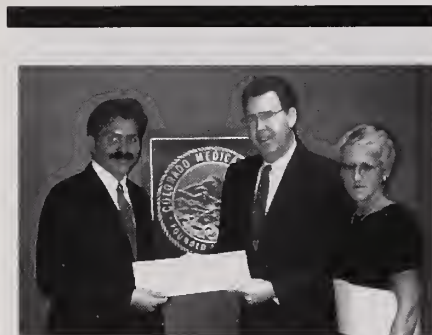


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An Embarrassment of Riches

by Philip Langlois



Philip Langlois accepts his \$500 check from CMS President David C. Martz, MD and CMS Executive Director Sandra L. Maloney.

The most common misperception of the health care debate today is the belief that the United States has a health care system. It does not. It would be far more accurate to say that many competing systems exist within the country. This is true for the type of care provided, whether by physicians or chiropractors, for the means by which the care is paid for, such as state, corporate, or private insurance, and for the way in which M.D.'s organize themselves, such as HMO's, partnerships, or private practice.

In a way this is an embarrassment of riches, for it can be very confusing to the individual without medical training to decide what sort of care to seek when they are ill. This can lead to intense frustration. For those at the lower end of the economic scale, the lack of choice can lead to even greater frustration and resentment. And there is reason for this, for it cannot be denied that the poor have high rates of sickness and death.

And this leads into the basic reason that the health care debate has begun in the first place. Many people can't afford modern American medicine. Many more, perhaps the majority, fear that the time will come when they won't be able to afford it. And it is particularly infuriating to egalitarian Americans to consider that they might die in a situation that a richer patient might walk away from.

The irony of this is that typically American values lie behind rising medical costs. Americans want to be the best at everything; likewise they consider technological solutions ahead of others. More and more

complicated technologies, more and more carefully researched and efficient drugs, and the more specialized health care providers needed for the above, are the basic reasons for the increase in the cost of medical care. The people have been given what they wanted; it just has not tasted as good as anticipated.

Many doctors would truthfully deny that cost is a factor for them. They will order the medicine or procedure that is best and not worry about the cost. However good intentions will not make more dialysis machines available nor allow the poor to purchase expensive drugs. There is a structural problem here that is beyond the capacity of doctors, acting alone or together, to solve. It is highly unlikely that anyone would accept a "freeze" in medical technology. (Who could impose it, anyway?) It is far more likely that costs will continue to rise at an alarming rate.

Some would say that preventive care, or health maintenance, is the solution to this problem. After all if the demand for health care drops, the price should also. There are several reasons, however, that this approach alone will not work. Firstly not everyone has the intelligence, education, or concentration to benefit from such care. Secondly, as your malpractice insurance rates must tell you, doctors are not as trusted by the general public as they once were. Most important our rapidly aging population will produce more sickness regardless of what anybody says or does. It is not hard to predict an explosion of health care needs.

Furthermore, the various solu-

Essay Contest Grand Prize Winner

tions or reorganizations of health care that have been debated in Congress and aired in the media are only skin-deep. None that I have heard of address the basic dilemma, we want the best technology and no one wants to pay for it. Nationalizing health care will not solve it; total privatization will not touch it. Persecuting insurance companies will not help; neither would giving them more power.

I do believe that there is a solution to this problem and that it requires strong action by the federal government. But this action should be indirect and supportive of present health care practices. The government does the most good when it clears the way for individuals and companies, not when it attempts to take over.

So what I mean is this: I know of no organization that is systematically searching for less expensive ways to cure disease at a level of success enjoyed by present methods. Certainly drug companies look for cheaper medicines so as to gain market-share, but in many cases a patient simply has to have a particular drug. With only one type of cure, there is no motivation to lower costs, or profits. Nor does this touch the problem of more expensive technology. In fact market-based approaches are not likely to work. Medical care is not like most commodities; the sick must have it.

This is my solution then. Let doctors, drug and insurance companies continue as they are. And let the government set up an organization that coordinates and conducts the search for less expensive medicine. Techniques, once found, could be

publicized, and the overwhelming majority of physicians would be glad to use them.

A good way to start such a search would be to conduct extensive international surveys of health care practices. For example, I have heard that Indian doctors have developed a method of healing burns using sterilized potato skins. It seems to work well, and is far less expensive than standard American practice. While I would not wish to be pegged to this particular example, it only stands to reason that successful techniques must exist in the poorer countries of the world. Necessity is the mother of invention.

Furthermore this approach would benefit the medical community. Since it is one of cooperation between many authorities, it sets a good example for a populace that has grown cynical upon the subject of authority. Should doctors take the lead in such an effort they would rightfully be seen as public benefactors, and that would lower the rate of malpractice lawsuits.

I will conclude by anticipating the main objection to my program. Some doctors would interpret this as going backwards or encouraging "primitive" medicine. Let me repeat that I want cheaper ways to do the same thing. I want to give doctors more choices not take any away. I do know that the public would love to save money; this is no mystery. I'm convinced of one other thing as well. We must absolutely avoid a situation in which the few have incredible health care and the many are frozen out. The country will not stand for that, yet that is where present trends are taking us.



An Embarrassment of Riches, written by 35-year-old Metro State College student **Philip Langlois**, is the grand prize winner in the Colorado Medical Society's Health Care Reform Essay Contest. Mr. Langlois says he got most of the ideas from his wife and from a college course in medical anthropology, although "one would have to be a hermit not to have heard or thought about healthcare over the last few years."

Mr. Langlois is recently married with two step children and another child on the way. He is majoring in Anthropology at Metro State and hopes to attend Iliff School of Theology to become a minister. He presently waits tables for a living.



Kent Petrie, MD named Colorado Family Physician of The Year 1995



Kent Petrie, MD, a 13 year member of the Colorado Medical Society, has been named 1995 Colorado Family Physician of The Year, it was recently announced by Richard A. Nicholas, MD, president of the Colorado Academy of Family Physicians (CAFP).

Dr. Petrie practices Family Medicine at Avon Medical Center, Avon, Colorado and also at Copper Medical Center, Copper Mountain, Colorado.

"Kent is an exemplary physician both clinically and also in terms of his capacity to cultivate and sustain highly positive, lasting relationships with his patients, his colleagues, and those he teaches," said Dr. Nicholas. "What really sets him apart, however, is his ability to do so many things, yet always have time to listen, be there for others, and exert a calming effect on those around

him. Kent also gives of himself unselfishly to his community and to his world. The man has a huge heart."

Dr. Petrie was born in Ann Arbor, Michigan in 1950. After graduating Cum Laude with a B.S. and Honors in Chemistry from Yale University in 1972, he obtained his MD from University of Virginia Medical School in 1976, this time with Alpha Omega Alpha Medical Society Honors. Dr. Petrie then completed his family practice residency at St. Paul-Ramsey Hospital, St. Paul, Minnesota in 1979. He was board

certified in Family Practice in 1979, the same year he joined Vail Mountain Medical, P.C., the family practice based multispecialty group in the Vail Valley, where he works to this day.

"A doctor's success is due to the team that surrounds him," explains Dr. Petrie. "I've been fortunate to be a member of an outstanding team here in Vail. My partners and office and hospital staff nominated me for this award without my knowledge, and to them I express my surprise and gratitude. I am honored by this award, but truly blessed to be working with them".

"Most of all," he continues, "I give thanks to my wife Martha and my two children, Molly and Joseph. They are my first priority, and my deepest source of pride and inspiration".

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immunizations among your patients. Call Lori Stonehocker Quick, RN, MSN at 303-692-2794 for more information.

18,000 Needed for Cancer Screening Trial

The University of Colorado Health Sciences Center is the local coordinator for a national cancer study run by the National Cancer Institute. In Colorado, about 18,000 people will be enrolled in the Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Trial. Nationwide, 148,000 people will become part of the study, which is designed to determine whether regular screening exams are useful in detecting these cancers at an early stage and, as a result, in reducing the number of deaths from these cancers. Half of the participants will be screened for the cancers while the other half will undergo their regular medical care.

Healthy men and women between ages 60 and 74 are being recruited to participate. Together, these cancers account for 43 percent of cancers diagnosed each year and 48 percent of cancer deaths. In total, about half a million Americans will be diagnosed with the cancers this year, and a quarter million will die from them. This trial may continue for up to 16 years.

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Do you know a physician who still makes house calls, who's been paid in produce and has delivered most of the kids on the local high school basketball team? If that colleague practices in a community of 20,000 or fewer, has a record of at least three years of continuous service and

demonstrates high quality and extraordinary dedication, he or she may be eligible for the Country Doctor of the Year Award.

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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to REFLECT)

by **Bill Pierson**, Managing Editor

The term, "Workers' Compensation" has earned itself a very bad connotation in business and in physician circles. Neither business people nor physicians want workers to be unprotected from on the job risks, but there has to be an ethical and more palatable way of handling the necessity of employee insurance against work-related injury.

Not long ago a friend told me about a recent Workers' Compensation insurance audit they (their family-owned small restaurant business) had undergone. The story went like this:

The workers' compensation insurance company sent in an auditor. This is customary, certainly in a restaurant situation. The purpose of the audit is to see that the employees covered by this policy are properly classified, based on the job injury risks. Obviously, a kitchen employee is at greater risk of injury than an office clerk.

In a restaurant, wait persons are classified as "kitchens staff" because they spend a great majority of their time on the job in the kitchen, around kitchen utensils, hot areas, substances under pressure, etc., any of which could jump out and bite anyone nearby. Office personnel are classified as clerks because they are handling mostly office machines and paper products at a sit-down work station. The risk is much different.

My friend's family-owned and operated business involves all of these things, and they have had their employees properly insured against risk for many years. There is, however, one difference: when business

is good (or at least when the rush is on) any of the administrative staff (mother, daughter, son) will automatically fill in to help the regular wait staff. One may be a cashier, while another may be waiting tables. This doesn't happen often. When I was in the bar/restaurant business, I did anything and everything. I bussed tables, washed dishes, waited tables, tended bar, cooked. . . anything because that's the nature of the business.

The auditor came in to this family business and said that during the past year a daughter had spent as much as 2 - 3% of her working time as a wait person, when she was previously claiming to be administrative (clerk) staff; therefore, he was reclassifying her, and declared premiums paid during the prior year were nearly \$2,000 short. The restaurant was billed for the difference.

My friend asked me "Is that right? Can they do that sort of thing?" My reaction was one of outrage. I asked is there anything in the policy which says that no matter what the condition, no matter how little the percentage of variation in the work, the insurance company has the right to go back and collect additional premium on a retroactive basis? If any such wording were involved in the policy, I would certainly find another carrier. He said he felt sure no one would sign an open-ended policy like that, especially when the premium is already as high as it is.

My feeling was that this was not right, and something should be done. The family agreed!

One tiny step for small business. . .

One huge attempted gouge stopped short.

A complaint was filed, the payment protested; the insurance company took nearly 5 months to investigate the case. Nevertheless, the company had to admit that there was no basis for their auditor's attempt at collecting a higher premium on prior business. Granted, if the person continues in this position in the future, an adjustment must be made now. . . covering future risk, but not retroactively. Hats off to the insurance company for adjusting its demands.. Hats off and a big cheer for the small business family who didn't just roll over to such demands. Sometimes, the little guy wins.

It was a small but precious victory.

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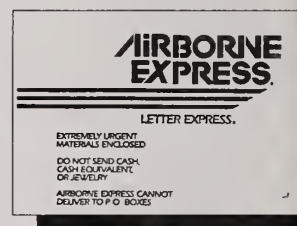
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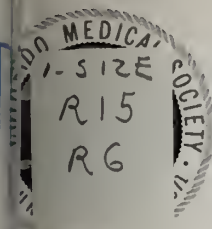
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Volume 92, Number 9

Managed Care: Is it a loss or a gain in your practice?

73% of those doctors surveyed said **it means a loss.**

(See "*Annual Physician Survey*" results page 311)

Capitation in the '30s: Doctors were being contracted in those days just as actively as today.

(See "*Dad was an IPA: Capitation in the '30s.*" by Dr. Jim Parker (on page 309)

"The Legacy of Leadership"

What have those past leaders of Colorado Medical Society left for the doctors who have followed them? A fascinating potpourri of issues, hurdles, stumbling blocks, crises and victories. (See the "*President's Letter*" page 307)

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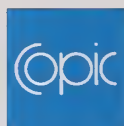
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countless hours
you've spent
working to become
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think how fast
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could jeopardize
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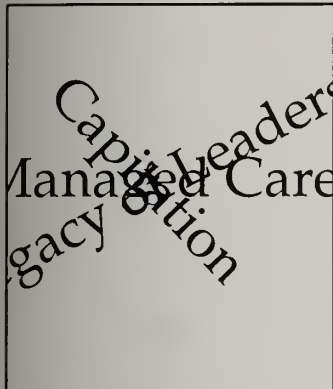
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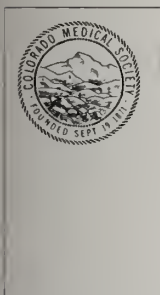
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Cover Story

The issues are legion, but *Colorado Medicine* provides some hard answers. Keep reading for useful information.



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*"Being a doctor has allowed me
to provide the best for my family."*

DR. JANELLE GOETCHEUS, MEDICAL DIRECTOR, HEALTH CARE
FOR THE HOMELESS PROJECT, INC., WASHINGTON, DC

Dr. Goetcheus says that raising her children in a health recovery facility for the homeless is one of the greatest gifts she has given them.

Her gifts to her patients are even greater. Caring for Washington's homeless for almost a decade, she despaired at seeing simple medical problems grow severe when patients lacked a clean, quiet place where they could heal. Her answer was to found Christ House, a live-in respite care facility for the homeless — and home to her family.

Today, this center is part of Washington's Health Care for the Homeless Project. As medical director of both, Dr. Goetcheus is serving in an even greater capacity, reviving health and hope in those she serves.

The Sharing the Care program donates Pfizer's full line of single-source pharmaceuticals to medically uninsured, low-income patients of federally qualified centers like Health Care for the Homeless, in support of those who, like Dr. Goetcheus, are part of the cure.

Sharing the Care: A Pharmaceuticals Access Program is a joint effort of the National Governors' Association, the National Association of Community Health Centers and Pfizer.



We're part of the cure.

Rehab News

NovaCare — At the forefront of the rehabilitation industry

NovaCare Outpatient Rehabilitation, formerly Therex Physical Therapy, provides an array of physician therapy services. They include orthopedic physical therapy, hand therapy and aquatic therapy. Our therapists average eleven years of professional experience and are dedicated to continuing education and professional growth. We pride ourselves in the establishment of treatment goals that include restoring the patient to maximum post-injury function and in the use of a team approach between physician, therapist and patient. Information and ideas are shared to accelerate progress toward mutually-based goals.

In addition, to help combat escalating worker compensation costs, NovaCare Outpatient Rehabilitation has implemented a proven approach to reduce workers' compensation costs while promptly and safely returning workers to the job. The program is called Work Injury Network/WIN®.

The goal of the WIN® program is early identification and prevention of problems before they occur. WIN® is based on a proven, progressive philosophy that treats injured workers like "industrial athletes" by using a sports medicine approach to care. From day one, the injured workers are involved in their own rehabilitation process by learning the mechanism of injury, proper work postures and contribution to their own care.

We offer 7 convenient locations and extended hours as well. For more information about our services and progressive treatments, please contact Vanessa Lewis-DeBoer or Marc Schneider at 303-696-6566.

NovaCare, Inc., is the leading rehabilitation management services company in the United States and is the nation's largest employer of rehabilitation professionals.



It's what's inside that counts



There's a branch of the military where you can enjoy the benefits of civilian life while you serve your country. *The Army National Guard*. There are new challenges in today's Army Guard like aerospace medicine and continuing medical educational opportunities. We offer experience you can't get any where else. If you're a doctor or still in medical school, talk to us. We'll work with you to meet your school or work schedule. For two days a month and two weeks a year discover what you've been missing. We offer

training throughout the world and now in Colorado the guard is providing medical assistance to our own citizens. Once again accepting a new and different type of a challenge. Ask about our benefits, including financial assistance for qualified residency and our flexible time commitment to you. For more information Call:

LT John Clifford
(303) 367-4397

"You can't tell the players without a scorecard."

and **THE** scorecard is the twice-monthly newsletter

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CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax[®]

by **Montgomery Little and McGrew, P.C.**

legal counsel to the Colorado Medical Society

Colorado's Hispanics rate high in behavioral risk factors

Hispanics are Colorado's largest ethnic minority population, according to the Colorado Department of Public Health and Environment, yet they do not differ from the overall population in rates of smoking, drinking or high blood pressure. They have lower rates of death from heart disease and cancer, but face significantly higher health risks from lack of health insurance, diabetes, being overweight, failing to have cholesterol

levels checked and failure to consistently use seat belts.

These are findings of the most recent Hispanic Behavioral Risk Factor Survey, which questioned over 600 Hispanic residents from Denver County, Pueblo County, and the Southeast/San Luis Valley area by telephone.

The report may be obtained from the Health Statistics Section at 303-692-2160.

Cyberspace—the newest location for medical practice

More and more, physicians must find ways of managing huge amounts of information. Everything from drug interactions and exotic diseases to managed care contracts and capitation agreements must be understood and integrated into the larger picture.

Now there are some resources available on the Internet and more are becoming available all the time. Two recent ones are "PracticeNet" and "The Medical Reporter".

PracticeNet features descriptions of practice opportunities nationwide that may include color photographs and eventually, videotapes depicting the opportunity location. The service is run by Merrit, Hawkins and Associates and concentrates primarily on primary care opportunities. PracticeNet is on the World Wide Web at <http://www.practice-net.com>. Get more information from Merrit, Hawkins at 800-876-0500.

The Medical Reporter is an online, monthly health magazine. It emphasizes preventive medicine, primary care, patient advocacy, education and support, as well as topic in sub-specialty medicine of interest to men and women. It has been published solely in cyberspace

since April of 1995 by Joel R. Cooper, a Denver based health care reporter whose work appears regularly in such publications as the Denver Business Journal. The web address for The Medical Reporter is <http://www.dash.com/netro/nwx/tmr/tmr.html>. Access is free. Call 303-337-6299 for more information.

Safety of Calcium Channel Blockers Questioned

The National Heart, Lung, and Blood Institute of the National Institutes of Health has questioned the safety of calcium channel blockers in a new report from an ad hoc panel convened in June. Short acting nifedipine, for instance, "should be used with 'great caution (if at all)'" says the report.

NHLBI Director Dr. Claude Lenfant says, "This statement is intended to provide a much-needed perspective on the safety and effectiveness of calcium channel blockers."

The report is based on a review of several studies and clinical trials, including a meta-analysis of 16 trials of nifedipine in patients with coronary heart disease.

The report is available online at fido.nhlbi.nih.gov or gopher://gopher.nhlbi.nih.gov/ or by calling the NHLBI Information Center at 301-251-1222.



Med Fax: Medico- Legal News

*by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, PC.
This column is not legal advice, but is for general information only. For help with specific problems, readers should consult an attorney.*

Living Wills and Medical Durable Power of Attorney

When it comes to a living will or medical durable power of attorney, are you like the cobbler's children who have no shoes or the lawyers who have no wills? If so, it's a problem that takes little effort to fix.

A living will and medical durable power of attorney give you the power to determine your destiny. At a critical time, they clearly define your wishes and relieve family members and loved ones of the awesome responsibility and guilt which can be associated with making life-or-death decisions.

All living wills and medical durable power of attorney documents are not created equal. They require careful attention to your personal ethical, moral, religious, and practical beliefs. Although they do not have to be, they should be more than fill-in-the-blank forms.

If you have any questions about a living will or medical durable power of attorney, the attorneys at Montgomery Little & McGrew, P.C., can help you.

Improper Recruiting Incentives

If you follow the news about Medicare and Medicaid anti-kickback laws you know that certain recruiting practices by hospitals can result in severe sanctions, including revocation of a hospital's tax-exempt status upon proof that it offered physicians illegal incentives to come on staff.

Earlier this year, the IRS issued guidelines and described several recruiting scenarios. Permissible scenarios include an agreement by an inner-city hospital to pay an OB's malpractice premium in exchange for treating a reasonable number of Medicaid and charity care patients; an urban hospital's private practice guarantee for a perinatologist for its neonatal intensive care unit; and a rural hospital's agreement with an OB-GYN to pay a \$5,000 bonus and malpractice premiums for a year, and to provide below-market rent on office space for three years. The forbidden

scenario described recruitment incentives amounting to payment for referrals offered by a hospital located in a medium to large metropolitan area.

Related guidelines referred to generally as STARK or STARK II guidelines apply to physician practices, and contain similarly severe sanctions for physicians involved in practices amounting to self-referral. Don't be unpleasantly surprised. Consult an attorney if in doubt about the nature of your own practices.

Physician As Employer

The chance of this happening to you is remote very remote. Nonetheless, if you are an employer, it bears consideration.

The Colorado Supreme Court recently held that when a non-employee child suffers prenatal injuries as a result of the negligence of the mother's employer, the employee is not limited to remedies available under workers' compensation law.

Mrs. Keefe worked at Pizza Hut when she became pregnant. Because she was suffering medical complications from her pregnancy, her doctor imposed work restrictions. Despite those restrictions, her bosses forced her to work hours and perform tasks violating her medical work restrictions. She delivered 3 months early and the child died 10 days later of medical complications arising from her premature birth.

Under workers' compensation laws, an injured worker's exclusive remedy for injuries that arise out of or in the course of employment and are proximately caused by the employment is recovery under the workers' compensation statute. The exclusivity provision effectively abolishes all claims accruing to any person on account of injury to an employee. Under the exclusive remedy provision of the workers' compensation act, certain injuries or damages sustained by non-employee, as it does to the injured employee.

However, the Court found that in this case the injury was to the child, not to the employee-mother. The child, when born, stands in the same position as any other non-employee member of the public and may sue the employer for injuries to the non-employee. Under general negligence principles, if a child dies after birth as a result of prenatal injuries, a surviving parent may bring a wrongful death claim derived from the child's injuries. Piecing together these principles, the Court held that Mrs. Keefe could sue her employer for damages recoverable under the Colorado Wrongful Death Act.

Why all the fuss? Under the wrongful death act, a party may recover up to \$250,000 plus medical and

***Continues on
following page...***

funeral expenses for damages resulting from the death of a child. The recovery may include damages for grief, loss of companionship, pain and suffering, and emotional stress. None of these elements of damage are recoverable under workers' compensation law.

Domestic Violence - Restraining Orders

The Colorado Legislature passed a number of bills during the part session concerning domestic violence. Among the changes are laws requiring physicians to report to law enforcement authorities injuries resulting from domestic violence. Another law requires parties seeking divorce, legal separation, child custody orders, or a determination of parent-child relationship to disclose any existing temporary or permanent restraining orders to prevent domestic abuse issued against either party by any court within 90 days prior to the filing.

Since June of 1994 when domestic violence made headlines, family courts have seen a significant increase in the number of petitions for restraining orders to prevent domestic abuse. Violence in the family was no secret before then; nor was the need to keep tempers in check, particularly during emotionally imbalanced periods of separation and divorce. For some years now, an automatic "temporary injunction" became effective upon the filing and service of a petition for dissolution of marriage or for legal separation. Under the automatic temporary injunction, parties are prohibited from "molesting or disturbing the peace of the other party".

Although the temporary injunction aims at preventing an escalation of emotions to the point of physical violence, it does not prohibit a critical element of

domestic violence: contact between the parties. Restraining Orders can and often do go both ways, prohibiting each party from contacting the other. Restraining Orders serve several functions: First, a Restraining Order clearly defines the degree of physical conduct permitted between the parties — typically, none; Second, the Order itself becomes a legally enforceable document to be shown to police in the event that one party attempts to violate the Order — most often, by attempting to have contact; Third, the document becomes a basis upon which the police can rely in removing a party from the vicinity of the other person; Fourth, the document forms the basis for further prosecution of the offender. Violation of the Restraining Order becomes a separate, distinct and sanctionable wrongful act, in addition to any harassing and violent acts carried out against the other party.

Sometimes Restraining Orders are used as swords rather than shields; however, that tactic is dangerous — not to mention disingenuous — and can backfire in the long run. A person who would lie about his or her safety will not be believed in other matters. (Remember the boy who cried "wolf"?)

They evidence the ultimate breakdown of the marital and family relationship and ask the Courts to step into private areas. Courts and law enforcement agencies are mandated to take all accusations of domestic abuse seriously. They also take seriously attempts to abuse this process in order to gain an advantage in a family matter.

Attorneys at Montgomery Little & McGrew, P.C. are experienced in family law involving all aspects of domestic litigation, including child custody, child support, parenting time (visitation), maintenance awards (alimony), and the division of property, assets and debts.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Advisory Council on Health Programs for Women and Children

Regular monthly meeting.

For information call Suzette Clark at (303) 692-2421.

American Association of Blood Banks

Ensuring a Predictable Donor Base: Marketing Models for the 21st Century

September 10-12, 1995

Hyatt Regency Denver, Denver, CO.

Contact: (303) 295-1234

Colorado Hospital Association

70th Annual Meeting—Transition Through Trust

September 13-15, 1995

Vail, Colorado

303-758-1630

American Society for Medical Technology

Intermountain States Seminar, "Renewal of Excellence".

September, 13-16, 1995

Jackson, Wyoming

Contact: Mary L. Minish, IMSS Publicity Chair, P.O. Box 3778, Jackson, WY. 83001

BioAgenda 2010

Shaping Colorado's Health Care Economy

September 21, 1995

Colorado Convention Center, Denver, CO

303-674-7436

Commission on Family Medicine

1995 Opportunities Fair, "Your chance to recruit physicians from the ten Colorado Family Residency training programs.

September 22-24, 1995

Copper Mountain Resort

Contact: (303)745-4275

American Medical Association

The 1995 Political Education Grassroots Conference
September 27-28, 1995

The Mayflower Hotel•Washington, D.C.

Contact: Department of Registration Services- 1-800-621-8335

Denver Medical Library

Third Annual Medical Informatics Fair

September 28-29, 1995.

1719 E. 19th Street, Denver, CO

Contact: The Denver Medical Library at (303) 839-6670

American College of Cardiology

Enhancing Quality and Value in Cardiovascular Care

September 28-30, 1995

Keystone, Colorado

800-257-4739

Fall Clinics of Montrose, Colorado

24th Annual Montrose Fall Clinics

September 29-30, 1995

Contact: Kathy Holman (303)-240-7397

American Academy of Orthopaedic Surgeons

Outcomes and Effectiveness in Musculoskeletal Surgeons

September 29-October 1, 1995

San Diego, CA

800-626-6726

Colorado Springs Osteopathic Foundation

The Just Allocation of Scarce Resources

October 19, 1995

Colorado Springs, Colorado

719-735-9057

Equity Management Systems

Winning the Investment Game

October 19-21

Scottsdale, AZ

800-257-2216

Joint Commission on Accreditation of Healthcare Organizations

8th Annual National forum on Health Care Quality

November 8-11, 1995

Chicago, IL

708-916-5800





David C. Martz, MD
President, 1994-1995

The Legacy of Leadership

The Colorado Medical Society Annual meeting in Aspen on September 8-10, 1995, is the 125th meeting of our organization. It is fitting that we should include a recent retrospective at such an anniversary. I have polled the CMS Presidents from 1970 to 1994 to summarize the major issues and/or crises of their term in preparation for this event.

Many have responded as of this writing in mid-August. Among the issues and crises were:

1. The withdrawal of malpractice insurance companies from Colorado;
2. The initial efforts to stabilize liability coverage by a contract with the Hartford Company;
3. The subsequent creation of COPIC at a time when "everyone" predicted that doctors could not succeed in the insurance world;
4. The creation of CFMC to allow physicians--rather than "others"--to assess appropriateness of care by physicians;
5. The ill-fated interest in building a CMS edifice;
6. The heroic efforts to save CMS from bankruptcy and to repay the stock investments in The Building made by many of our members;
7. Various CMS staff departures under complex circumstances that threatened both the continuity and the

integrity or our organization.

These are but a few of the obstacles that faced us in recent years--yet in every circumstance we have risen to the challenge with fortitude and innovation.

I also invited the Past Presidents to offer nuggets of wisdom based on their year of leadership, from which the following comments were gleaned:

1. Consider a more adventurous, futuristic approach.
2. Figure out which way the doctors are going and get out in front and lead them.
3. One must be diplomatic yet be positive, having one's facts straight.
4. Find the many dedicated physicians around you and put them to work.
5. Any significant project begun by the Society needs to have extensive initial planning with advice and direction given by professionals (in that field) before the Society commits itself.
6. Stay close to grassroots and trust your instincts.
7. Do what is right: Be part of the solution rather than remaining part of the problem.
8. Principle can attract support, but success insures it.

And so it has been with a sense of history and heritage that we have faced this year's concerns: we carry on the work of our colleagues rather than stand alone in a moment of time. It is our responsibility to carry

on the legacy we inherit, and then to leave it in the hands of those who follow us.

We have certainly dealt with some very thorny topics over the past twelve months. Among the more notable subjects have been:

1. The implementation of the CMS-HMO association "White paper", the first of its kind in the country--a landmark effort based on **negotiation** rather than litigation or legislation with managed care organization;
2. The hiring of Dr. Leigh Truitt to be the first liaison physician mediator with the managed care organizations--he is already hard at work and will report on his first months of activity to the House of Delegates on September 8th;
3. The first attempt of non-physician providers to practice medicine independently by legislative decree via the Nurse Practice Act, which challenged our abilities to keep the house of medicine speaking with a single voice amidst a cross fire of conflicting goals (next year it's the Pharmacists--and others?);
4. Our first major attempt at proactive health care reform legislation with the Point of Service mandate which Dr. Karlin championed, and from which we all learned much to help us in the Health Care Reform arena in the years ahead;
5. The creation of a universal credentialing form, utilizing the input of the numerous organizations and interests who would be affected by its implementation;

(Continued on following page)

PRESIDENT'S LETTER

(Continued)

6. The pursuit of rural health issues including physician recruiting and retention, economic balance, job gratification, educational and resource facilitation, and legislative relief;
7. The successful creation of a joint venture between Colorado Physician's Network and Rocky Mountain HMO to establish a new generation of managed care with physicians at the helm as they have never been before. We will be coming to YOUR community to meet with you face to face in the last 3 weeks of September. Don't miss the chance to hear about it firsthand and get in on the ground floor!).

Like those who preceded us, we have laid the groundwork for other efforts which may come to maturity in the months ahead:

1. The development of a managed care task force to identify the stickiest points of confusion and conflict, and crystallize potential solutions to be proposed to the HMO association;
2. An IDS task Force to assist us with the confusing array of "opportunities" that confront us with HPOs and other organizational buyout options;
3. A contract analysis service for our membership, to assess the potential "problems" in a given managed care agreement;
4. More wide-sweeping proactive health care reform legislation, hopefully in concert with coalitions between medicine and other interested parties;
5. A private venture into data collection and analysis to replace the Data Commission which was terminated last year, again in concert with other interested parties; and finally,
6. A careful review of the organizational structure of CMS so that we can keep pace with the changing needs of Colorado physicians.

Among the principles we have attempted to follow this year have been:

1. Listen and Ask before Telling;
2. Progress is easier if it doesn't matter who gets the credit;
3. Assembling a team and respecting their input is more effective than dictating one's own insights;
4. Diversity of backgrounds among appointed associates gives strength that far outweighs the efficiency of cronyism;
5. Understand and accommodate the viewpoint of the minority position rather than force the will of the majority (or the leadership);
6. Communicate bi-directionally with the grass roots of the organization;
7. Make **NEGOTIATION** the preferred approach to conflict resolution;
8. Don't be afraid to risk innovative solutions--provided the benefits far outweigh the risk;
9. Learn from those who oppose you--they will tell you what your friends should but won't;
10. Form coalitions--even if with strange bedfellows--to attain a needed goal;
11. Provide vision for things that might be, and facilitate the path thereto if your associates are persuaded;
12. If it could be better. . . **help it change.**

It has been a special (and unplanned) joy to serve you this past year. The team which has surrounded us has been spectacular, and all credit for what may have been achieved in the past 12 months must be shared by many. I, for one, shall never forget the challenges of '94-95--much less the people who provided the solutions.

Thank you from the depths of my heart for your support!

Plan to Attend the Colorado Physician Network Forum

The Colorado Physician Network and Rocky Mountain HMO have joined forces to design, implement and operate a cutting-edge health care program. Out of this association will come a line of health care products to meet the needs of most Coloradans and a state-wide network of providers to deliver the care. It will put the patient first and give each physician control over medical decisions.

Don't miss this
opportunity to find out
how you can become
a part of this
exciting venture!

Plan to join us for:

The Colorado Physician Network /Rocky Mountain HMO Forum

**Friday, September 8
1:15 - 2:15 p.m.
Ritz-Carlton - Aspen
The Mill Street
Club Room**



Dear Editor:

I am working on a book on medical ethics and would like to enlist the help of other physicians to answer this question: Have you ever faced an ethical dilemma, and if so, how did you resolve it?

I am interested in all aspects of medical ethical-human experimentation, ethics of reproductive technology, abortion, medical treatment of the uninsured and poor, malpractice, physician assisted suicide, the right-to-die (why some doctors do not honor Living Wills), genetic counseling, genetic manipulation, euthanasia, kidney, lung and heart transplant, use of fetal tissue, or any other situation concerning an ethical dilemma.

Please reply to:

Claude A. Frazier, M.D.
4C Doctors Park
Asheville, NC 28801

Dad was an IPA - Capitation in the '30s

My father, Dr. Joe Parker, who graduated from the University of Colorado School of Medicine in 1931, accepted a salaried position as company physician in the Veta Mines in Telluride, Colorado, following a rotating internship at the Union Pacific Hospital in Tacoma, Washington.

Money in those depression years was scarce and some of Dad's classmates were accepting positions

for as little as \$166.00 per month in Government CCC camps. An offer from Telluride mines to provide employee health care included \$25.00 a month for serving as a City Health Officer, \$25.00 a month for being County Health Officer and \$2.00 per month for each employee (and family). This guaranteed an income of about \$240.00 per month. Having been raised in Grand Junction, Dad was anxious to return to the Western Slope and accepted the offer.

This salary agreement was modified in 1937 by capitated contract that provided "the services of a physician and surgeon for the care and treatment of all such persons and their families in the case of sickness of or injury to such men while they are employed by the employer." The contract went on to say that the physician would maintain a "commodious and sanitary hospital" and would provide hospital care for up to four months for "accidents, injuries or ailments, or diseases sustained, contracted or developed while an employee." Obstetrical cases and venereal diseases were excluded.

The contract required the employer to collect each month the sum of \$1.50 per employee, and \$2.25 for each employee with dependents.

The contract was modified in 1939 to include the times when "it is desirable for Veta's employees that Doctors or medical specialists other than Dr. Parker himself be called upon to assist in the treatment of the cases covered by the contract". The agreement went on to say that "if the

Doctor shall feel it is desirable to call in medical assistance or specialists, the cost of such special treatment shall be shared equally by the Company and the Doctor". Obviously he needed a stronger contract negotiator than himself.

Needless to say the personal rewards of being of service far outweighed the financial gains of practice. Vacations, or even a day off were rare. My father was never out of Telluride for more than 24 hours at a time from 1935 to 1946. I remember Dad talking of the wonderful new insurance program, Colorado Blue Cross and Blue Shield. Finally, he was in a fee-for-service program and could see financial gain from long hours of patient care.

Is capitation the answer for health care in the 90's and into the new century? From my father's experiences, I would say no. Patients tended to become very casual in the utilization of services that were "their right" to receive. Dad even had evening office hours Monday through Friday 7:00 to 9:00 to accommodate the day shift personnel. If Joe Parker were alive and in practice today, I'm sure he would prefer to receive fee-for-service compensation. I know that is the way that I prefer to practice.

Dr. Jim Parker, Grand Junction

EXECUTIVE DIRECTOR'S UPDATE

by Sandra L. Maloney, which usually appears in this space, will be seen again in the October '95 issue of *Colorado Medicine*, due to vacation.

Workers' Compensation rule changes adopted

Conversion factors changed slightly to give increase in some areas

Colorado Medical Society has learned that on August 8, 1995, Barbara P. Kozelka, Director of the Division of Workers' Compensation, adopted, with minor changes, the proposed amendments to the medical fee schedule in Rule XVIII and the impairment rating guidelines presently found in Rule XIV and proposed for repromulgation as Rule XIX.

Two major changes to the current fee schedule rule are new conversion factors as listed below and the adoption of the *McGraw Hill Relative Values for Physicians* and the *Relative values for Dentists*, all of which will replace the current "Workers' Compensation Relative Value Study".

Adopted conversion factors:

Medicine and E&M Services	\$6.51/RVU*
Physical Medicine	5.92/RVU
Anesthesia	33.48/RVU & time
Surgery	78.53/RVU
Radiology	16.12/RVU
Pathology	12.27/RVU
Dental	28.46/RVU

• RVU: Relative Value Unit

If you wish to obtain copies of the Workers' Compensation rules, write: Public Records Corporation, P. O. Box 18186, Denver, CO 80216. You can phone them at (303) 832-8262. Cost for an initial set of rules are as follows:

Rules of Procedure	\$17.60,
or	
Rules of Procedure including Treatment Guidelines	\$35.00
plus sales tax and postage	\$ 1.24

If you wish an annual subscription to rules:

Rules of Procedure	\$36.00
or	
Rules of Procedure including Treatment Guidelines	\$45.00

The new rules will become effective with dates of service on or after October 1, 1995.

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000

How Long Must a No-Fault Carrier Pay for Treatment?

When an insurance adjuster says bills will no longer be paid because a patient reached maximum medical improvement (MMI), what do you do? You should object.

The Colorado no-fault statute does not state that benefits terminate once a patient reaches maximum medical improvement. It provides:

C.R.S. § 10-4-706(b) "Compensation without regard to fault, up to fifty thousand dollars per person for any one accident for payment of all reasonable and necessary expenses for medical, chiropractic, optometric, podiatric, hospital, nursing, x-ray, dental, surgical, ambulance and prosthetic services, and nonmedical remedial care and treatment rendered in accordance with a recognized religious method of healing, per-

formed within five years after the accident for bodily injury arising out of the use or operation of a motor vehicle;..." (emphasis added).

The statute allows treatment of symptoms even though it will not cure the problem. Palliative care provides long or short term symptom relief and is covered under the Colorado statute even if the patient has reached maximum medical improvement. This does not mean that you can indefinitely treat a patient who has been involved in an automobile accident. Common sense must be applied to your decision as to whether treatment should be paid for by the carrier.

When the cost of treatment outweighs its benefit, then it is no longer reasonable and necessary. But professionals can and do often disagree

on "reasonableness," and prompt and proper communication with an adjuster may prevent payment problems. Written opinions should apply the specific facts and circumstances of a patient's treatment plan to the statute's guidelines. Do not use a form letter — tailor each letter to each patient.

If the carrier still refuses to pay, then a determination will have to be made by an arbiter or a jury.

For further information please contact:

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Gelt, Fleishman & Sterling P.C.
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Denver, Colorado 80202
(303) 861-1000

Physician's Financial

Bulletin

**Special Insert Number 9 for
Colorado Medicine, September, 1995**

An exclusive member service of the Colorado Medical Society in collaboration with Chase Manhattan Investment Services, Inc.

THE EDITOR'S NOTES

The Stock Market's Euphoric Sentiment

In a recent issue of the *Mercer Forecast*, you would have found the following examples of market euphoric sentiment:

"Equity funds have topped \$1 trillion in assets, a mere 27 months after exceeding the \$500 billion mark. Now, even "Consumer Reports" is ranking mutual funds. Bill Gates of Microsoft, made the cover of "TIME", and Dan Dorfman's huge following (as seen by sharp moves in the stocks he comments on) is a clear sign of market excess. The Trump Plaza IPO itself is a sign of a top, as is the growing popularity of Technical Trading software; in a recent issue, "Investors Business Daily" had 18 different ads for Trading software. Finally, Ted Turner's plan to create a new business channel is a bull market phenomenon."

The Mercer forecast also provided the following humorous list of the top 10 signs of an upcoming market top:

- 10) Michael Jordan leaves the NBA to start his own mutual fund company.
- 9) Matsushita purchases the Vanguard Group.
- 8) Off track betting begins providing discount brokerage services.
- 7) Alan Greenspan's face is put on Mt. Rushmore.
- 6) Tom Hanks signs to play the lead in the Jesse Livermore story
- 5) Robert Vesco is named manager of the Cuba Fund.
- 4) U.S. Robotics is added to the Dow Industrials.
- 3) Dan Dorfman becomes editor of the New Yorker
- 2) The dividend yield of the S&P 500 drops below the Bank of Japan's discount rate.
- 1) Warren Buffett hosts a Salomon Technology Conference,

In the words of the editors of the Dick Davis Digest, "Carpe Diem.....but Caveat Emptor." Need I say more?

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The Bulletin Board

Introducing the **NEW**

"Market Insight Conference Call"!

Be a participant with
Roxbury Capital Management
at Noon, Saturday, September 20, 1995 - - -

Just call **1-800-456-8215**.

Which way will the
stock and bond markets go?

Investment advisory and security services are provided by Chase Manhattan Investment Services, Inc. (CMIS), a subsidiary of the Chase Manhattan Bank, N.A. CMIS is a member of the NASD and SIPC.

Securities involve investment risk, including the possible loss of principal. They are not FDIC insured bank deposits and are not guaranteed by, or obligations of, The Chase Manhattan Bank, N.A. or CMIS.

EDUCATIONAL WORKSHOPS

As summer (what happened to June?) comes to a close, the Physician's Seminar Series will initiate its Fall series starting in October. The sessions will be presented by Chase Manhattan Investment Service¹ and will be held in the evenings from 5:30 pm - 7 pm and centrally located at Chase Manhattan headquarters on I-25 and Colorado Blvd. The following are the topics and dates scheduled for this Fall.

October 17, Tuesday Low inflation equals Lower Yields/
How to select the alternatives.

November 14, Tuesday No Loads - No Front, No Back, No Surrender Fees

December 12, Tuesday End of Year Tax Strategies

Be looking in the Physician's Financial Bulletin for updates on each monthly workshop and your individual invitation.

Mark your calendar for noon Wednesday, Sept. 20th!

If you want to participate in a discussion with Roxbury Capital Management, a Santa Monica, California based professional money management firm which manages over \$2 billion in corporate, foundation, and Individual account funds, call (800) 456-8215 at Noon, MST, on Wednesday, September 20, 1995. (All calls limited to 50 participants). Roxbury will provide their insight into the economy, and the directions of the stock and bond markets for the balance of 1995 and election year 1996. Have your questions ready..... This conference call is being set up for you to be a full participant.

AGAIN, HERE'S THE NUMBER TO CALL:

(800) 456-8215

at Noon, MST, on Wednesday, September 20, 1995.

FOOTNOTES:

1. Investment advisory and security services are provided by Chase Manhattan Investment Services, Inc. (CMIS), a subsidiary of the Chase Manhattan Bank, N.A. CMIS is a member of the NASD and SIPC.

How much does it really take to retire?

William M. Holben, CPA

Today's conventional wisdom is that you should strive for a retirement fund of about \$1,500,000 by retirement age. Of course, this wisdom requires numerous assumptions, such as your anticipated income tax rate, your required retirement income, and several others.

The fact is, your comfortable retirement and providing the funds necessary to insure for it can be likened to a vacation. Before you can begin the detailed planning of how to get there, you must have some fairly clear idea of your destination. Once you have determined your destination you must determine the general itinerary,

the standard of comfort you will require upon arrival and the length of your stay. Once all of this has been determined, then you can actually budget for the vacation and begin to plan for the journey required to arrive at your destination.

With retirement planning, the journey is represented by the years between now and your anticipated arrival at your retirement. If your retirement is fairly imminent, then perhaps \$1,500,000 will meet your needs. If your retirement is more distant, then the impact of inflation will cause your retirement income requirements to be much higher, and will cause the required fund to exceed, perhaps greatly, \$1,500,000.

Having taken many successful vacations, you intuitively know the secret to a successful journey and vacation, and that secret applies to retirement planning as well. The secret is, of course, to continually and frequently monitor your progress toward your objective. Review your goals and objectives each year or two, modify them as appropriate, review the progress that you have made during the last year or two toward your last goals, and make whatever adjustments are called for.

And now is the time to begin your planning. With financial planning, if you are young time is your ally, and as you age it rapidly becomes your enemy.

The dream of a simple formula approach to selecting your retirement destination and your planning journey to arrive there is, unfortunately, a fantasy. Unlike a vacation, there are no tours available to retirement. You must simply develop the personal skills to act as your own advisor, or find a competent advisor to work with and, in either case, revisit your plan every year or two. If you do, then your retirement, like most everything else you have done, will be successful, and you will arrive at the destination you anticipated.

William M. Holben is the managing director of Holben, Boak, Cooper & Company, a Denver CPA firm.

Market Data

INDICATOR	12/31/94	6/22/95	8/29/95
Prime Rate	8.50	9.00	8.75
6 Month T-Bill	5.88	5.42	5.34
30 yr T-Bond	7.50	6.47	6.72
DJIA	3834.44	4589.64	4608.44
S & P 500	459.27	551.07	560.00

Mortgages-New Purchases

NO DISCOUNT FEE - NO OBLIGATION FEE

	12/31/94	6/22/95	8/29/95
30 yr fixed	10.0%	8.26%	8.7%
7 yr fixed	9.375%	7.458%	7.8%
5 yr fixed	9.125%	7.208%	7.5%

These rates are subject to change without notice.
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Taking Charge

Judith A. Lundquist and Diane Weisert

In our previous column, we discussed the importance of women becoming financially active. This, if you recall, is due to the fact that 90% of women will be responsible for finances at some point in their lives. Unfortunately, this point in our lives frequently occurs at a time of crisis or a life changing situation. You should not be adding the trauma of becoming a new investor while you are learning to cope with new life situations.

We need to take charge and become financially organized today. Your finances may be as day to day as maintaining a checkbook or as complicated as setting up an estate or managing a multimillion dollar portfolio. Your reality probably lies somewhere in between.

Getting financially organized is not as difficult as it sounds if you go step by step. First, you must **determine your financial needs**. Some examples are providing for a college education, purchasing a second home, preparing for retirement, providing luxuries or financial independence. You may find you have many needs or perhaps just one.

After you have defined your needs, then set your objectives. These are more specific than the needs. The first one to consider is the time frame: When do you want to retire? Or when will your child be ready for college? Then a dollar amount must be estimated, so there is a specific figure to work towards. Will your child be attending an instate university costing approximately \$15,000 per year or a private college at \$25,000 per year? Another key factor in getting organized is to determine with how much and when you will fund the investments you are making to achieve your objectives. The most common alternatives are having a lump sum of money to begin with, then adding dollars on a predetermined time frame. One

example is the IRA or Individual Retirement Account. The need is retirement and Uncle Sam allows us to contribute \$2000 of earned income on a yearly basis. One last objective is to set a desired yearly return. This comes down to how much volatility (bounciness) you are comfortable with in your portfolio. Women, generally, are quite averse to risk but we have to get a better return on our investment than is lost to taxes and inflation.

Remember, it's not fun being a bag lady.

The third step is to **develop a plan**. This leads to some interesting questions such as who will actually direct the investment portfolio. Three likely options include yourself, a professional, or an acquaintance. Probably a combination of the three is what will be utilized. "What, me direct?" you say. You can educate yourself through classes, reading, seminars and talking with others to become a more learned investor. Finding an investment professional is not difficult but it takes some searching to find a competent person with whom you feel comfortable. Remember, you will be discussing your financial matters with this person. Names are available through referrals, advertisements, or perhaps the dart board. The question of where you will do your investing might be answered by the "who", but if not, the options include an investment club, financial planning office, a bank or a brokerage house, which could be a full-service or a discount broker.

The fourth step is the most important, and that is to **get started**. Just because we like to have money to spend but don't like to have to worry about having to make it or manage it is no excuse to delay starting. We need to take charge, even if we start with baby steps.

Judith A. Lundquist and Diane Weisert are Financial Consultants at Chase Manhattan Investment Services¹ and can be reached at (800) 223-2140 or (303) 782-8000.

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Denver, CO 80222.

CMS



CHASE

Jack, please contact me regarding (please circle topics):

Home Mortgages

Education Debt Refinancing

Retirement Plans

Estae Planning

Portfolio Analysis/Investments

Equity Line of Credit

Tax Planning Strategies

Financial Planning

Trust Services

Auto Financing

☐ I would like to attend "**Taxes, Lawsuits and Family Conflict**" at 5:30 pm on Thursday, August 17, 1995.
There will be _____ people in my party.

Name _____

Address _____

Phone (H) _____

(W) _____

Best time to contact: _____

How to bullet-proof a child's inheritance (Asset Protection)

by Bruce A. Schilken

In this time of frequent divorce and economic uncertainties, asset protection has become a hot topic. During the past several years. Family limited partnerships or offshore trusts have been recommended frequently to transfer assets away from the reach of potential creditors. This article discusses a method of asset protection using trusts that (1) include spendthrift provisions and (2) apply the generation skipping transfer ("GST") tax exemption.¹

GST Tax Planning

For years, wealthy families have created impenetrable financial fortresses by using trusts. They have gained the additional benefits of simple asset protection as they set up "dynasty trusts" to transfer wealth from generation to generation.²

These strategies also apply to more modest estates. Utilizing the benefits of a dynasty trust with the average client will not only satisfy the client's estate tax savings concerns, but also will protect the client's children from losing their inheritance to creditor claims and divorce settlements.

The Dynasty Trust

A dynasty trust allows the children of the grantor (creator of the trust) a lifetime use of the trust property. Any remaining principal goes to the grandchildren of the grantor.

During the lifetime of a child of the grantor, a dynasty trust either allows all the income from the trust to be payable annually to the child or gives the trustee the discretion to add the accumulated income to the trust principal. At the discretion of the trustee, the principal of the trust can be paid toward the health, education, maintenance and support of the child. The principal of the trust is not included in the child's estate on the date of the child's death.

Asset Protection Through Dynasty Trusts

There are two separate means of asset protection under a dynasty trust. First, the trust should include spendthrift trust provisions to protect the principal and income from creditors' claims (see discussion under the heading "Spendthrift Trust Provisions"). Second, the trust, rather than the child, owns the assets held under a dynasty trust. The assets are held for the benefit of the child. The grandchild, as vested remainderman, receives final distribution of the trust principal.

Under a dynasty trust, the child can receive all the benefits from the trust assets but can never directly own them. This is important for the following three reasons :

1. Creditor protection during the life of a child. During the life of the child, the child's creditors cannot attach the trust assets because the child does not legally own the trust assets. The child has only a beneficial interest in income and principal distributions, rather than direct ownership in the trust assets. This is especially important if the child is in an occupation vulnerable to lawsuits. The dynasty trust will protect assets from negligence claims against the child (in which high damage awards and large legal fees are commonplace).
2. Savings, tax savings and protection from creditors during probate of the child's estate. In a properly drafted dynasty trust, the principal of the trust is not included in the child's gross estate for estate tax purposes. The child's estate will not be liable for estate taxes on the value of the principal of the trust. The trust principal will not be subject to the child's creditors under the probate proceedings.
3. Trust principal not becoming marital property. In Colorado, the Uniform Dissolution of Marriage Act provides that marital property does not include inherited property.³ However, the problem is that the inheritance may eventually be converted into marital property. For example, a family home may be

purchased with inherited cash. The home is then titled in joint tenancy with right of survivorship. Joint tenancy property is marital property. The advantage of providing for the child with a dynasty trust is that if the child divorces, the trust principal will never become marital property.

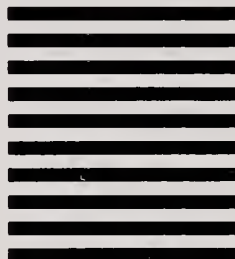
As mentioned above, the benefits of a dynasty trust are not merely for wealthy families. A child receiving an inheritance of even \$100,000 could need the creditor and divorce protections as described above. The asset protection provided by this type of trust appeals especially to parents who do not favor their child's choice of spouse.

REFERENCES

1. I.R.C. 2631(a)
2. I.R.C. 2601
3. CRS 14-10-113



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by **Bill Pierson, Director**
CMS Member Services

CMS Physician's Financial Program Annual Survey

Now in its third year, the Colorado Medical Society/Chase Manhattan **Physician's Financial Program** has provided a valuable service to CMS members. Even those who do not partake of any of the workshops or seminars provided through Chase Manhattan benefit by being able to compare their own financial status or position with their peers. Perusing the following survey results tells you a great deal about positions, attitudes, risk-takers, and predictions.

In case you are not aware of the **Physician's Financial Program**, I'll explain briefly:

Chase Manhattan brings together experts in various financial areas to provide informational seminars. Among these experts will be professionals in accounting, taxes and tax planning, practice management, financial planning, mortgage banking, real estate, stocks and bonds, and other fields. Some of these will be (but certainly not limited to) employees of Chase Manhattan,

Every other month, **Colorado Medicine** carries the **Physician's Financial Bulletin**, a newsletter about these subjects as well as some current market indices.

In the spring of the year, Chase Manhattan and Colorado Medical Society team up to survey financial needs and interests of CMS member physicians.

Many physicians don't like to admit to using any such commercial service; however, over the three year period, I have found that a large percentage of our membership has been involved in one or more of the services offered through the **Physician's Financial Program**. The yearly survey is one of these services, and over 10% of our membership responded this year. Following are this year's survey results.

COLORADO MEDICAL SOCIETY/CHASE MANHATTAN INVESTMENT SERVICES "PHYSICIAN'S FINANCIAL PROGRAM" Annual Physicians Survey Results

Your Financial Outlook (Please circle answer)

1. How would you describe your outlook for the U.S. economy over the next 5 years?

Positive: 198--50.64% **Negative:** 52--13.30% **Uncertain:** 141--36.06%

2. Do you employ physician assistants or advanced nurse practitioners?

Yes: 121--31.02% **No:** 269--68.98%

If so, do you believe this to have a positive financial impact on your practice?

Yes: 119--79.33% **No:** 27--18.04% **Other:** 4--2.67%

3. What is the approximate percentage of loss or gain in your practice income as a result of managed care?

Gain: 34--11.48% 0-20%: 27--79.41% 20--40%: 5--14.70% 40-100%: 2--5.89%

Loss: 219--73.99% 0-20%: 123--57.48% 20--40%: 82--38.31% 40--100%: 9--4.20%

No Change: 43--14.53%

4. Do you plan on selling (or are you considering the sale of) your practice in the near future?

Yes: 69--18.70% **No:** 300--81.30%

Have you had a recent practice valuation? **Yes:** 53--14.89% **No:** 303--85.11%

(Continued on following page)

5. Have you devised a plan to lessen the impact of taxes on your income?
Yes: 226--58.55% **No:** 160--41.45%
6. How do you view your overall financial strategy?
Adequate: 274--70.99% **Inadequate:** 112--29.01%
7. Do you have an individual financial plan? **Yes:** 301--76.79% **No:** 91--23.21%
8. How often do you review/revise your financial goals?
Weekly: 2 --.61% **Monthly:** 15 -- 4.59% **Quarterly:** 28 -- 8.57%
Semi-Annual: 48 -- 14.68% **Annual:** 144 -- 44.03% **Other:** 90 -- 27.52%
- Comments:** "Frequently/Constantly/I don't know/Not often enough/Every 2,3,4,5 years/Daily/Never"
9. At what age do you plan to retire?
45-50: 6 -- 1.54% **50-55:** 10 -- 2.58% **55-60:** 58 -- 14.91% **60-65:** 107 -- 27.50%
65-70: 108 -- 27.77% **Other:** 100 -- 25.70% (Most of these were already retired; some responded "Never".)
10. Are you confident that your current investments/plan will provide adequately for your retirement?
Yes: 166 - 42.02% **No:** 104 -- 26.33% **Uncertain:** 125 -- 31.65%
11. On whom do you rely for investment advice?
 Broker: 59 -- 12.52% Fin. Advisor: 94 - 19.96% Friends: 15 -- 3.19%
 CPA: 60 -- 12.73% Attorney: 12 -- 2.54% Spouse: 13 -- 2.77%
 Family: 16 -- 3.40% Self: 80 -- 16.99%
 Other: 122 -- 25.90% ("Publications/Newsletters/Multiple Sources")
12. What do you expect in annual returns from your overall investment portfolio?
< 5%: 6 --1.74% **5-7.5%:** 41--11.91% **7.5-10%:** 110--31.98%
10-12.5%: 142--41.27% **12.5 -15%:** 10 -- 2.90% **15-17.5%:** 16 -- 4.66%
17.5 - 20%: 4 --1.17% **>20%:** 3 -- 0.88% **Other:** 12 -- 3.49%
- Are you actually getting this rate of return? **Yes:** 235 -- 80.0% **No:** 96 -- 29.0%
13. What percentage of your investment assets are in:
- | | | | | | |
|----------------------|--------------|-----------------|-----------------|-----------------|------------------|
| Cash: | 0-20% | 20 - 40% | 40 - 60% | 60 - 80% | 80 - 100% |
| | 161: 69.39% | 50: 21.56% | 11: 4.74% | 6: 2.59% | 4: 1.72% |
| Fixed Income: | 0-20% | 20-40% | 40 - 60% | 60 - 80% | 80 - 100% |
| | 64: 31.38% | 89: 43.62% | 26: 12.74% | 11: 5.40% | 14: 6.86% |
| Equities: | 0-20% | 20-40% | 40-60% | 60-80% | 80 - 100% |
| | 24: 9.19% | 49: 18.78% | 62: 23.75% | 67: 25.68% | 59: 22.60% |
| Other: | 0-20% | 20-40% | 40-60% | 60-80% | 80-100% |
| | 57: 44.19% | 33: 25.59% | 17: 13.17% | 5: 3.88% | 17: 13.17% |
14. Do you participate in a retirement plan? **Yes:** 324--89.39% **No:** 62--16.07%
Type: Pension/Profit Sharing -- 88; IRA -- 60; SEP -- 28; KEOGH -- 23; 401K -- 51; Other -- 46.
15. Are you familiar with investment policy statements? **Yes:** 189 -- 51.09% **No:** 181--48.91%
 Does your retirement plan have one? **Yes:** 161--58.76% **No:** 113--41.24%
16. Do you have an updated will? **Yes:** 271--69.13% . **No:** 121--30.87%
17. Do you have an estate plan? **Yes:** 209--54.71% **No:** 173--45.29%

(Continued on following page)

18. Have you made arrangements for management/distribution of assets in your estate?

Yes: 244 -- 64.56%

No: 134 -- 35.44%

19. Where do you think home mortgage rates will be at the end of 1995? _____ In 5 Years? _____

	Up	Down	5-7%	7-9%	9-11%	>11%	Other
In 1995:	12--4.0%	13--4.4%	1--0.33%	158--53.0%	87--29.2%	5--1.7%	22--7.4%
5 years:	25--12.0%	2--1.0%	2--1.0%	47--22.6%	84--40.4%	32--15.4%	16--7.7%

20. Have you refinanced your home recently? **Yes:** 157--41.09% **No:** 225--58.91%

21. Are you considering buying a first or second home? **Yes:** 63--16.76% **No:** 313--83.24%
Are you considering building a first or second home? **Yes:** 64--17.02% **No:** 312--82.98%

22. Are you repaying education expenses? **Yes:** 91--23.70% **No:** 293--76.30%

23. With how many banks or brokerage firms do you have accounts?

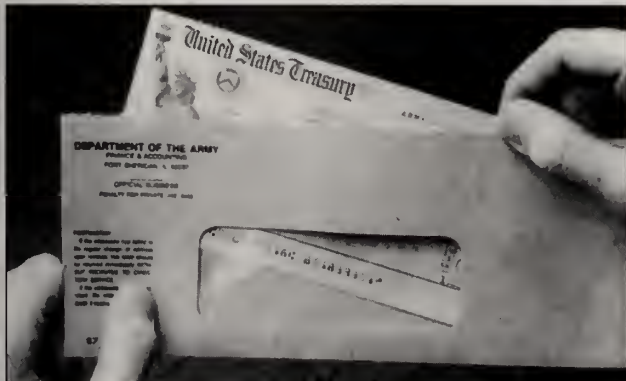
0 to 4 Firms	4 to 8 Firms	8 to 12 Firms
317--83.87%	57--15.08%	4--1.05%

24. How often do you consult with your:

	Wkly	Monthly	Qtrly	Semi Ann.	Annual	Other
CPA	9--2.78%	47--14.50%	79--24.39%	81--25.00%	83--25.62%	25--7.71%
Attrny	6--2.48%	16--6.61%	21--8.68%	27--11.15%	85--35.12%	87--35.96%
F.A.	5--2.30%	33--15.13%	59--27.06%	45--20.64%	46--21.10%	30--13.77%

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Medical Decision-making for patients who no longer can choose for themselves

by Fredrick R. Abrams, MD



Colorado doctors need to become familiar with the five different ways medical decisions may be made for patients who lack capacity to make decisions for themselves. Each of the methods has unique functions. To advise patients about them, doctors need to know

about the various forms and purposes. The attending physician plays a key role in all of them because the doctor may start each process by noting in the record the cause, nature, and expected duration of the patient's incapacity to make choices. The table below summarizes some

major points and I will add a few more comments to emphasize their specific utility.

Before describing their differences, these procedures have in common the preservation of all patients' well established legal right to refuse or consent to any medical

Decision-making methods for patients that lack capacity to choose

ALTERNATIVE	DECIDED BY	ESTABLISHED	EFFECTIVE	HOW IT WORKS
I. Guardian (CRS 15-14-301)	Court	After you become incompetent	After you become incompetent	1. Evidence must be presented to the Court establishing the need to have a guardian appointed. 2. Person selected by the Court makes decision considered to be in your best interest. 3. May require subsequent Court involvement, if scope of decision making authority becomes an issue.
II. Durable Power of Attorney (CRS 15-14-501)	You	While you are competent	After you become incompetent	1. No preliminary Court involvement. 2. Person selected by you makes decisions presumably in accordance with your general wishes and considered to be in your best interest. 3. May require subsequent Court involvement, if scope of decision-making authority becomes an issue.
III. "Living Will" (CRS 15-18-101)	You	While you are competent	After you become incompetent	1. No preliminary Court involvement. 2. Document authored by you embodies your own specific wishes which must be honored and followed. 3. No subsequent Court involvement, unless document's compliance with statute is specifically challenged.
IV. CPR Directive (CRS 15-18.6-101)	You	While you are competent	After you become incompetent	1. No preliminary Court involvement. 2. Unique numbered document filled out by you and countersigned by doctor. 3. Prohibits cardiopulmonary resuscitation(CPR). 4. Specific necklace or bracelet may be used to identify you as having a CPR Directive.
V. Proxy Decision Maker (CRS 15-18.5-101)	"Interested Persons" Spouse, Parent, adult child, sibling, grandchild, any close friend likely to know patient's wishes.	After you become incompetent in the absence of an Advance Directive	After you become incompetent	1. No preliminary Court involvement 2. A physician notes patient lacks decisional capacity. Enters the cause, nature, and projected duration. 3. Physician or appointee notifies one or more "Interested Persons" of patient's loss of decisional capacity. 4. "Interested Persons" select a proxy.

treatment, even life-sustaining treatment. Of course, when a patient does have the capacity to make decisions, there is no need for any special procedure. Patients who have thought in advance of a crisis situation (when they might be unable to express their wishes) have made an "advance directive". Colorado offers three of these, The "living will", the **Durable Power of Attorney for Health Care (DPAHC)**, and the **CPR Directive**.

The "living will" is the instrument for patients who often express themselves by saying, "If I'm going to die, I don't want to be hooked up to a bunch of tubes and machines that just prolong dying". It's a very "narrow" document, designed for patients that are "terminal", and there is at minimum a 48 hour wait after two doctors have documented the terminal condition. You can see it's never an emergency and there's little need to carry a wallet card. In fact that's probably a bad idea because someone might misinterpret intentions and make less effort than is warranted, missing the best chance for a good result from an indicated resuscitative effort. This directive is one way for a patient to refuse nutrition and hydration to avoid prolonging the permanent "persistent vegetative state" like Karen Quinlan's 9+ years and Nancy Cruzan's 8+ years).

The agent appointed by the patient in the DPAHC has all the rights the patient would have had including access to everything necessary to make decisions as the patient would. However, the agent has no more authority than the patient, and cannot force doctors to do anything to which they would not have acceded for the patient. Often the patient, in addition to discussing his/her desires and values with the agent in advance of a crisis, will include instructions and limitations in the document.

The CPR Directive is probably the one for which the doctor plays the most critical role. It is a DNR order that goes into effect immediately and it does not permit the deliberation that the other instru-

ments allow. It is not the right tool for a relatively healthy person who wishes to avoid high tech interventions at some future time when they might be "terminal". Again, that is best done by the "living will" and/or the DPAHC. The CPR Directive is for the home hospice patient or perhaps the frail elderly person for whom death is neither unexpected nor unwelcome. It is primarily to avoid inappropriate resuscitation when 911 has been mistakenly called by a panicky bystander or someone that does not know that resuscitative attempts would be inappropriate. This document must be countersigned by a doctor so that patients will be warned of the consequences and be sure that their actual intention is to avoid resuscitation under any and all circumstances, even when the outcome can be expected to be very good.

In the event the patient has not left any "advance directive" there are still two other methods for decision-making. The procedures that doctors usually follow have been made into law, in order to protect doctors and families that act in good faith from later legal liability." Interested persons" (see table line V) can appoint a "Proxy" decision-maker who can act just like the agent in a DPAHC. Only if there is a decision to withhold or withdraw nutrition and hydration is there any difference. Then the proxy must obtain a consultation assuring the patient is in an irreversible neurological state,

The most authoritative situation occurs when a court has appointed and empowered a guardian to make healthcare decisions. Usually there has been a hearing and evidence presented as to the need for a guardian, and who would be most suitable to act in the patient's best interest. Anyone that feels the decisions are not being made in the patient's best interest may go to court regardless of any previous rulings or documents. This, of course, includes the doctor who believes that following the instructions of agents, proxies, or guardians would not be in the patient's inter-

ests. However, some patients have higher values than life and/or health, and a bad medical decision is not necessarily against the patient's (perhaps unique) interest.

The "living will" is for "terminal" patients only and is never a hasty decision nor an emergency situation. It is to avoid unwanted terminal interventions.

The **Durable Power of Attorney for Health Care** is more versatile than the "living will". It may be applied when circumstances cannot be precisely anticipated (not only for terminal patients).

The **CPR Directive** is to avoid unwanted, inappropriate CPR. But it is an instantly effective DNR Order. Doctors must be sure the patient does not misunderstand and make one prematurely.

The proxy can be used when no "advance directive" has been made. "Interested persons" choose a spokesperson to consent or refuse. For the most part, the role is just like the DPAHC agent.

When agreement can't be reached or there is dissatisfaction with a decision or spokesperson, a court can be approached to appoint a guardian to make decisions, as a final measure.

All of these devices are to assure that the patient's right to make healthcare decisions is preserved, even when he/she can no longer express them directly, and to protect against future legal actions those persons who act in good faith to carry out the patient's wishes.

NOTE: A copy of the order form for supplies and information regarding *Colorado Patient Directives* is on the following page.

Ed. Note: Dr. Fredrick Abrams is co-director of the Center for Health Ethics and Policy, Graduate School of Public Affairs, C. U. Denver, and Associate Clinical Professor of Obstetrics and Gynecology, UC-HSC. He is a Diplomate of the American Board of Obstetrics and Gynecology and a Fellow of the American College of Obstetricians and Gynecologists.

Order Form for Supplies and Information Regarding Colorado Patient Directives

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ATTN: _____

Address: _____

City/Zip: _____

Type of Facility: _____ Telephone () _____

Quantity	Description	Unit Price	TOTAL
	Ten Pack ENGLISH: Five Patient Directives Five Authorized Agent Directives	\$5.00	
	Ten Pack SPANISH: Five Patient Directives Five Authorized Agent Directives	\$5.00	
	Twenty-Five Pack ENGLISH: Patient Directives	\$12.50	
	Twenty-Five Pack SPANISH: Patient Directives	\$12.50	
	Twenty-Five Pack ENGLISH: Authorized Agent Directives	\$12.50	
	Twenty-Five Pack SPANISH: Authorized Agent Directives	\$12.50	
	CPR Directive Information Packet	\$3.50	
Add for postage:			
If order total is			
	Under \$25.00	add \$3.00	
	\$25.01 to \$50.00	add \$5.00	
	\$50.01 to \$100.00	add \$6.00	
	\$100.01 to \$200.00	add \$7.00	
	\$200.01 to \$300.00	add \$8.00	
	\$300.01 to \$400.00	add \$9.00	
	\$400.01 to \$500.00	add \$10.00	
TOTAL:			

CMS/6/95

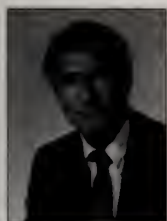
- All orders must be prepaid before they will be shipped
- Allow 2 weeks for delivery
- Make checks payable to Colorado Medical Society
- Mail to: P. O. Box 17550, Denver, CO 80217-0550

Please copy this form and mail direct to CMS. Questions: Call 303-779-5455.



Highlights of the Board of Directors Meeting—July 14, 1995

- Copic:** Dr. Jerome Buckley, CEO, reported on several items of interest, 1) Gadrian and the Copic Agency have moved into a new building, close at hand, 2) Naomi Sullivan has been named as the new Director for Gadrian, 3) the issue of the CMS discount is being studied but it appears as though the practice will continue, and 4) growth of insurance includes the addition of four more hospitals and Health-One. Dr. Buckley thanked CMS for their willingness to update the phone system.
- Medical Executive Group:** Ms. Pennie Joseph reported that this was the last meeting for Ms. Tammy Nelson, Larimer County. Ms. Nelson is moving out of state. Ms. Joseph indicated that Larimer and Weld County Medical Societies may combine staff duties.
- CMSA:** The Board of Directors voted to support the Alliance efforts during the month of October in promoting the nationwide effort to "SAVE - Stop America's Violence Everywhere".
- AMA:** Dr. Richert Quinn was elected to the AMA Council on Constitution & Bylaws at the AMA Annual Meeting in June.
- Board of Directors:** The Board approved the 1995-96 Fiscal Budget and commended CMS Staff for their efforts in controlling administrative costs. The Budget will be forwarded to the House of Delegates for ratification.



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The Board approved a proposal to form a University Component Society and a resolution regarding this matter will be sent to the House of Delegates.

The Board approved a request from the Workers' Compensation/ Personal Injury Committee to establish policy that states CMS opposes the use of Medicare RBRVS by payers other than Medicare and a resolution regarding this matter will be sent to the House of Delegates.

P

ivate Sector Action in Weld County

by Michael P. Thompson

"The private practice physicians in Greeley were already the biggest source of medical care to the indigent population. The Children's Clinic is a continuation of that tradition."

Everybody talks about the medically indigent, but some people actually do something about it. Of course, most physicians see a few indigent patients in their offices, but there are still a lot more who don't have access to that avenue. This is especially true of children.

Dr. Donald Cook of Greeley decided to galvanize his community to meet this problem. In an interview with *Colorado Medicine*, Dr. Cook said that there are three to four thousand kids in Weld County on Medicaid who have no primary care physician. They get their medical care primarily in the Emergency Room. Many others are not even eligible for Medicaid in the first place. The Sunrise Clinic, operated by the federal government, simply does not have the capacity to serve all the children who need care, and with the tightening of the federal budget, that is not likely to improve.

Dr. Cook decided to take seriously the call for the private sector to take over some of the functions being carried out by governmental agencies. In the process, he discovered a tremendous amount of community support for such an idea. His fellow physicians donated medical equipment, insurance people, lawyers, community groups and even the local governments got involved. North Colorado Medical Center made a \$250,000 grant to supplement the grants from the city and county governments. The city of Greeley contributed a half acre lot in the part of the city with the highest density of indigent people.

What about a building? They found it would cost three to four hundred thousand dollars to build a suitable facility. That problem was solved by the discovery that the hospital in Yuma had an old medical clinic building they no longer needed. Moving it to Greeley cost only \$85,000. It has 3,300 square feet of space, including 10 patient rooms, an accident treatment room and office space.

Four part-time physicians make up the medical staff. The Children's Clinic also employs a full-time nurse practitioner and six other staff people, plus family practice medical residents, who rotate through. After a couple of months of operation, the patient flow for the clinic continues to increase. Payment is on a sliding scale. Future plans call for a comprehensive pediatric clinic.

Dr. Cook says that one of the big problems with getting indigent care to the residents of Greeley is that the medical offices are mostly clustered around the hospital, but most of the indigent people live in a different part of town. He hopes The Children's Clinic will make a big impact on the immunization and teen pregnancy rates in Weld County by being near the people it is designed to serve. They coordinate many programs with the county health department, to bring more access to medical care to Greeley's indigent. In addition, the clinic's Spanish speaking staff can help some of the monolingual residents who have missed out on health care because of cultural factors.

Dr. Cook refuses to take all the

"The largest medical clinic in Greeley was seeing ten times the number of Medicaid patients that the federal poverty clinic was and the local FP Residency program was seeing two and a half times that number."



Donald Cook, MD (center) is joined by Bob Francella, Children's Clinic director, as he receives his award from Joe Olbrys, Wyeth-Lederle Vaccines and Pediatrics territory manager.

After our interview with Dr. Cook, it was announced that he had been awarded the American Academy of Pediatrics' Community Access to Child Health (CATCH) Planning Grant. He is one of only 19 physicians nationwide and only two in Colorado to receive such an award. The grants are funded by Wyeth-Ayerst Laboratories.

credit for this successful outreach, "The whole community has pulled together to help us," he said.

The city council has been a great help, as has the hospital foundation and the Rotary Club, as well as many private citizens. In addition, Dr. Cook hopes the idea will catch on, "I think it's going to be a model that could be duplicated over and over again."

Why did he do it? "The largest

medical clinic in Greeley was seeing ten times the number of Medicaid patients that the federal poverty clinic was and the local FP Residency program was seeing two and a half times that number," says Dr. Cook. The private practice physicians in Greeley were already the biggest source of medical care to the indigent population. The Children's Clinic is a continuation of that tradition, and it's a tradition that can be duplicated in your community.

I ntegrated Delivery Systems:

What are they and why are they here?

This is part two in a continuing series on Integrated Delivery Systems. Please refer to Colorado Medicine for May, 1995, pages 174 and 180. Part three will enumerate the different models of Integrated Delivery Systems.

In the past decade, especially the last year, a growing array of integrated delivery systems (IDS) have emerged. An IDS is basically a network of providers organized to deliver a continuum of health care services. Greater integration is achieved the more inclusive the network is of both physician and hospital providers, the greater the ability to enter into risk contracts, the broader the range of services available, and the greater the ability to efficiently provide the services needed by the population served. There are many different models, but the goals are very similar. In his book "Integrated Health Care" Dean Coddington states "The reason for the formation of integrated health care systems usually relate to positioning for the future, gaining competitive advantage, controlling costs, accessing capital and improving quality of care."

Medicine is moving away from being a cottage industry and into organized delivery systems. The drivers of that change include 1) public and social awareness of underserved populations, 2) pressures to decrease the cost of health care, 3) the focus on patient outcomes, 4) new types of reimbursement such as capitation, 5) demands by physicians for greater flexibility in practice and lifestyle arrangements, and 6) a fear of losing patients. Of interest to CMS and our members is that physicians retain governance, professionalism and practice satisfaction and that physicians reestablish healthy physician/patient relationships (recognizing the

continuum of care and need for a flexible system to allow physicians to provide that care) throughout this time of great organizational changes.

The premise is that if we explore the sale of physician's practices to third parties we will probably find that a loss of governance, professionalism and control of clinical decision making result. However, in some circumstances an increase in practice satisfaction may also result. **The counter point to selling practices is the formation of physician organizations.** In these scenarios, the physicians remain in control of clinical decision-making, maintain their professionalism and a degree of governance or self-determination. Why should physicians consider participation in integrated delivery systems? It certainly seems that such systems will be key in the evolving health care delivery system of the not to distant future. And, as Yogi Berra would say: "When you come to a fork in the road - take it."

On the plus side, integrated delivery systems typically experience efficiencies in the delivery of health care by the economies of scale created. Additionally, the more integrated the system is, the more opportunity there is for strategic planning among all participants. Such systems also become bigger players at the negotiating table with payors and therefore have the potential to increase access to patients (or at least, not cause a loss in patient access for those involved). Integration also increases the access to capital which may enable these systems to position themselves for

"An IDS is basically a network of providers organized to deliver a continuum of health care services."

the future.

The down side of integration varies depending on the level of integration which has been achieved. They require change. There may be a loss of autonomy. Your traditional book of business may be dictated by the system (i.e. you may give up your Medicaid patients if the group does not want to treat this population). You will have to get used to being a part of a group culture.

Again, according to Dean Coddington's "Integrated Health Care" there are 10 major characteristics of successful integrated delivery systems:

1) Physicians play key roles in the overall leadership of the organization,

2) The organizational structure provides common management and coordination of all elements of the integrated system,

3) Primary care physicians are economically tied to the system,

4) Primary care locations provide full geographic coverage of the system's service area,

5) The system is appropriately sized for the needs of the market,

6) The physicians within the system are themselves integrated,

7) The system controls its own financing mechanisms (usually an HMO) and/or has the ability to enter into "single signature contracts" with other health plans or large employers,

8) The financial incentives of physicians, hospitals and health plans are aligned,

9) Communication systems are

in place to provide ready access to information, and

10) The system has access to capital and the ability to allocate financial resources.

Physicians need information to allow them to assess their situations and move forward in a timely manner. There is no one right route to increased integration. Often the degree of integration evolves as there are demonstrated results which impact the willingness of those involved to move forward. Immobility will make physicians dead in the water. The starting point depends on who has the initial vision but regardless of the starting point for the process, the physician organization is a key element.

The essential issues for physicians to keep in mind in the formation of groups are:

1) **Professionalism:** meaning the physicians establish standards, police themselves and provide for continued growth and education of their members.

2) **Governance:** Self Determination - includes decisions regarding how you pay yourself and direct control over practice satisfaction.

3) **Control over clinical decision-making**

4) Pricing/Value

The next article on IDS will review models of physician organizations which are part of integrated delivery systems.

For more information, call the CMS Division of Health Care Policy at 303-779-5455 or 1-800-654-5653.

Physician-Controlled Network Joint Ventures: Antitrust Considerations

by Thomas P. McMahon

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If there is one thing in the United States that seems as certain as death and taxes, it is that legislatively mandated health care "reform" is an idea whose time never arrived. Aside from political realities, rapidly evolving developments in the marketplace, occurring at increasingly dizzying pace, appear to have rendered the concept moot. Not only patients, but doctors too, are affected by these revolutionary changes.

Today, independently practicing physicians are increasingly pressured to come together in some fashion to contract with third-party health care managers to provide medical services to businesses, families and individuals. However, such joint action is fraught with antitrust peril for the unwary. The greatest risk is that independent, otherwise competing physicians acting collectively to negotiate fee schedules with third parties may be viewed as engaging in *per se* illegal price fixing.¹ Other significant antitrust issues that may arise include unlawful group boycotts and concerted refusals to deal, also often relating to fees.²

Lending credence to such concerns is the fact that the federal, and certain state, antitrust enforcement agencies have been extremely active in recent years with respect to joint physician arrangements. There have been a number of civil penalty and injunctive actions,³ and the Antitrust Division of the U.S. Department of Justice also has conducted several grand jury investigations and the first criminal prosecution in the health care area in fifty years.⁴ In

view of the serious antitrust pitfalls, this article suggests a method for qualifying for antitrust "safety zones" or achieving certain minimal antitrust "comfort zones" with respect to joint conduct by physicians.

General Fact Pattern

The joint action in which physicians are most likely to become involved is participation in physician-controlled network joint ventures within a particular medical specialty or across multiple specialties. Such networks generally contract to provide health care services to subscribers at reduced rates and commit to avoid providing unnecessary medical care. By their very nature, these ventures involve collective agreement by participating physicians on fees and other significant terms of competition, as well as joint marketing of the physicians' services through the network. The ventures also tend to involve medical practices that are not completely integrated — that is, the physicians continue to compete with one another for patients outside the health plans served by the network.

A venture often takes the form of an independent practice association (IPA) or a preferred provider organization (PPO). In either event, participating physicians are health care providers in the IPA or PPO. Regardless of form, the network ordinarily markets itself to and solicits contracts from insurance companies, health maintenance organizations and other third-party payors.

Such a venture endeavors to provide medical services locally, regionally or statewide. Numerous physicians may become involved, constituting a significant percentage of all doctors in the included specialties within the locality, region or state served. Where the network is unable to obtain desired geographic coverage through a participating physician in a particular specialty in one or more locales, it may seek to contract there with an allied health care professional (such as physician's assistant, nurse anesthetist, optometrist).

If the venture is member-owned, it is likely to require an initial capitalization fee of several thousand dollars per physician and additional periodic financial assessments. Operating costs may be paid out of a percentage "withhold", which also may be utilized to pay for administrative and management services and to establish an incentive bonus pool. Often, bonuses are paid to participating physicians for compliance with utilization, quality, referral and other criteria.

Economic risks associated with membership in the network include the possibilities that: (1) the entire capital and other investment made by members could be lost; (2) the venture could underestimate its operating costs, reducing the economic benefits of participation; and (3) ongoing economic losses could be incurred if "capitation" amounts (third party payments to the network consisting of fixed fees per patient) are insufficient in light of utilization rates. Members also run the personal and economic risk of legal challenges to the network or its activities under federal or state law, including antitrust and Medicare/Medicaid fraud and abuse statutes. Finally, the evolution of the health care industry could reduce or eliminate the economic benefits of the venture.

Certain contracts obtained by the network are likely to involve fee-for-service arrangements providing for discounted fee schedules, and others will provide for reimbursement on a capitated basis. In either or both cases, the venture will

perform utilization review, quality assurance, peer review and other similar functions, and may seek to develop data demonstrating its efficiency and cost effectiveness. It ordinarily also will provide billing and other services in connection with joint contracts.

The venture will negotiate uniform fees to be charged by network members to their party payors for specified services provided under contracts with the venture. Participation in the venture may be exclusive or non-exclusive — that is, either prohibiting members from individually entering into agreements with other networks, IPAs or PPOs, or from contracting directly with third party payors; or not restricting their ability to do so. If participation is non-exclusive, the network would not limit its members' ability to set their own fees or other terms of competition for medical services provided outside the venture contracts.

Federal Guidelines

In the fall of 1994, the Federal Trade Commission (FTC) and the Antitrust Division (together, "Federal Agencies") jointly promulgated revised federal antitrust enforcement guidelines for the health care area (Guidelines),⁵ including physician-controlled network joint ventures.⁶ Consequently, physicians seeking to establish or considering participation in such networks, and their advisors, must be familiar with both the Guidelines and evolving antitrust precedents. Because the two are not congruent in all respects, legal and business analysts and advisors must consider not only possible review and challenge by the Federal Agencies but also by state antitrust enforcers and private parties.

Antitrust Safety Zones

The Guidelines recognize that network joint ventures can provide significant procompetitive benefits because of their potential for providing quality health care services at reduced rates.⁷ Accordingly, the Guidelines — unlike the case law — establish certain antitrust safety zones for physician joint ventures

within which, absent "extraordinary circumstances", the networks will not be challenged by the Federal Agencies.⁸ A network may qualify for antitrust safety zone treatment if it meets the two-pronged test of being comprised of (1) no more than a certain maximum percentage (30 percent if the network is non-exclusive, 20 percent if it is exclusive) of the physicians in each included specialty who have hospital staff privileges and practice in the relevant geographic market and (2) who share substantial financial risk.⁹

Physician Percentage Participation Ceilings

To qualify for the more lenient 30 percent physician participation ceiling, a network must be non-exclusive *in fact*, rather than simply purporting not to be exclusive.¹⁰ Regardless of whether a network is non-exclusive or exclusive, the Guidelines note that the relevant geographic market for the delivery of physicians' services generally is localized.¹¹ All of the examples in the Guidelines relate to local markets, such as a town, metropolitan area or county.¹² Similarly, in the context of announcing that it would oppose the merger efforts of Parkview and St. Mary-Corwin Hospitals in Pueblo, Colorado, an FTC official stated recently that health care markets tend to be localized in nature and that twenty-five miles is a likely distance limit.¹³ All of this is consistent with the antitrust case law, which tends to view health care markets for patient services as being local in nature.¹⁴

Consequently, even if a non-exclusive or exclusive network were comprised of less than 30 percent or 20 percent, respectively, of all physicians in each included specialty statewide with hospital staff privileges, that likely would not suffice for blanket antitrust safety zone protection for the venture as a whole. Rather, the appropriate percentage limitation probably would be applied to each included specialty on an individual, local-market-by-local-market basis. Thus, a given network may exceed the applicable participating physician

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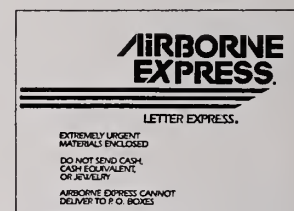
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percentage ceiling in one or more included specialties and relevant geographic markets and so may not qualify for blanket antitrust safety zone protection.¹⁵

Integration/Financial Risk Sharing.

The second factor in qualifying for antitrust safety zone protection is economic integration involving the sharing of "substantial" financial risk. In that regard, the Guidelines use examples of situations where services are provided at a capitated rate, or where there exist significant incentives to achieve cost containment goals—such as use of a substantial withhold, where compensation is distributed only when certain goals are met.¹⁶

Capitation involves payment to the network by a third-party health care payor of a predetermined, fixed amount per covered patient in return for the venture's provision of all specified health care services to those patients for the term of the contract, regardless of the level of services actually used.¹⁷ The risk of economic loss from overutilization is borne by the network and its physician-providers, rather than by the third-party payor. This encourages the venture and its members to manage their provision of medical services carefully.

What constitutes a sufficiently substantial withhold incentive in noncapitated situations, where fee-for-service contracts are involved, is less clear. The Guidelines use the example of a 20 percent compensation withhold devoted exclusively to inducing successful implementation of cost containment and quality goals, such as utilization review, quality assurance and the like.¹⁸

In a real-world situation, however, it is conceivable that the cost of operating the network—including payment of fees for marketing, management and administrative services—also could be a component of the withhold. If so, in order to meet this prong of the antitrust safety zone text for fee-for-service contracts, a venture would need to withhold significantly more than 20 percent of the collections generated and then allocate that amount

among operational costs, service fees and the 20 percent incentive bonus. As a practical matter, physicians are not likely to participate in a network where the percentage of compensation withheld would be that great. Thus, a venture employing a combination-type of withhold scheme would probably not be able to qualify for antitrust safety zone protection.

Assessment.

A network will qualify for antitrust safety zone protection in certain physician specialties in relevant geographic markets (where the 30 percent or 20 percent physician ceiling is not surpassed) and certain other situations (involving capitated contracts or 20 percent compensation withholds attributable solely to meeting cost-containment and quality goals). Nevertheless, the venture may exceed the maximum participating physician percentage limitation in some specialties in other markets. Likewise, in non-capitated situations, the amount of any real cost-containment withhold may not be sufficiently substantial to constitute significant risk sharing. Accordingly, it may be assumed that in certain particular specialties, markets and situations, a network will not qualify for antitrust safety zone protection.

Rule of Reason Analysis

However, the Guidelines recognize that physician joint ventures falling outside the antitrust safety zone do not necessarily present significant antitrust concerns, and may in fact be procompetitive.¹⁹ In non-safety zone situations, the Guidelines provide for "rule of reason" analysis if the physicians in the joint venture either share substantial financial risk or offer a new product producing substantial efficiencies.²⁰ The former criterion is discussed above, and the latter is a central goal of any network joint venture. Accordingly, the rule of reason should apply.²¹

From an antitrust advisement perspective, however, this very situation is the most difficult one with which to deal. Here, account must be taken both of the four-step

analytical approach and standards posited by the Guidelines²² and of the at-least-slightly-different legal standards enshrined in antitrust case law. The analysis to be employed and its possible results are as follows.

Identification of Relevant Market

Under antitrust case law, the relevant market is comprised of two components—product or service, and geographic.²³ The latter is dealt with above. The case law defines the former as consisting of services "reasonably interchangeable by consumers for the same purposes."²⁴

The Guidelines also recognize that the relevant market is comprised of these same two components and presume that all services provided by a particular physician specialty constitute a distinct relevant service market. They also note, however, that there may be instances involving significant overlapping of services by different physician specialties that justify inclusion of those additional specialties in an expanded relevant service market.²⁵

The latter concession is helpful in at least two respects. For one thing, it seems equally applicable to determination of antitrust safety zone qualification as to rule of reason analysis. By so expanding the service market, this approach would increase the likelihood that the maximum participating physician percentage for safety zone protection will not be exceeded. Moreover, even if safety zone protection were not achieved, under the rule of reason, this approach would decrease the likelihood of anticompetitive effects in such a diluted market.

This approach also raises two issues. First, there is the question of whether allied health care professionals must or should be included in defining the relevant service market. There can be no argument that, just as between different specialties, there can be an overlapping of services between physicians and allied health care professionals in certain fields. As indicated above, having more rather than fewer providers considered part of the

market is helpful in terms of avoiding possible anticompetitive consequences. However, the entire thrust of the Guidelines is aimed at physicians with hospital staff privileges, not at allied health care providers who lack such privileges. Nevertheless, the case law does not appear to take quite so restrictive an approach.²⁶ The likely result under the case law is that, for overlapping services, allied health care professionals will be considered part of the relevant service market.

Second. A network often includes both generalists in a particular specialty and subspecialists. In such a situation, it is not crystal clear that the Federal Agencies would view all specialists as participating in the same relevant service market. As the converse of the overlapping specialties approach, it is at least conceivable that the Agencies might seek to define separate service submarkets comprised of discrete subspecialty services. If that is the case, it is more likely that anticompetitive effects could be described in such narrow subspecialty markets. Even then, however, if the venture is nonexclusive, that fact would go far toward alleviating possible anticompetitive concerns and consequences.²⁷

Evaluation of Likely Anticompetitive Effects

Under rule of reason analysis, an examination must be made of market power—the ability to raise price or exclude competition.²⁸ Just determining the existence or absence of market power is often dispositive in rule of reason analysis. Percentage market share is viewed as a key indicator of such power,²⁹ although a number of other factors are looked to as well.³⁰

The Guidelines follow the same approach. Where, in the particular relevant market, there exist a number of other physicians (or, in terms of the case law, allied health care professionals) who would be available either to form competing joint ventures or to contract directly with health insurance plans, the Guidelines (and case law) find little cause

for concern because the existence, much less the exercise, of market power is unlikely.

This is particularly true where the joint venture is nonexclusive. In such situations, the Guidelines recognize that a network does not impose any significant anticompetitive restriction on the ability of its members to affiliate with other such ventures or to contract with other health insurance plans.³¹ Consequently, from the standpoint of achieving a “comfort zone” under the rule of reason, perhaps the most effective approach is for a network to be nonexclusive in fact.³²

Evaluation of Likely Procompetitive Efficiencies

Once any potential anticompetitive effects of the network are ascertained, any potential procompetitive efficiencies likewise must be identified and the two sets of possible effects balanced against each other. To pass muster under the rule of reason, the greater (or less) the likely anticompetitive effects, the greater (or less) must be the offsetting likely procompetitive efficiencies.³³ The Guidelines recognize that not all physician joint ventures are equally likely to lower the costs of health care to consumers. Viewed as particularly helpful are cost savings from the assumption of financial risk by participating physicians (that is, due to capitated fees or substantial withholding as an incentive to achieve cost-containment and quality control). Other possible efficiencies are reduced administrative costs, improved utilization review and case management, quality assurance and any economies of scale—virtually all of which are goals of the network venture.³⁴

Of course, once a network actually begins operation, in the not-too-distant future it should be able to demonstrate actual efficiencies based on concrete data. That could go a long way toward staving off a challenge from any source.

Evaluation of Ancillary Agreements

If the venture includes collateral agreements or conditions that unreasonably restrict terms of competition and are unlikely to

make a significant contribution to the legitimate purposes of the network, further examination is necessary to determine whether such provisions are reasonably necessary to achieve procompetitive efficiencies.³⁵

By its own terms, the joint venture must not impair the physicians’ ability to see their own fees for services they provide outside the network. Likewise, members should never use the venture to affect non-network pricing. Because physicians presumably will lower their fees (in return for greater volume) for patients treated through the venture, it is unlikely that they will seek to use the network to fix *similarly low* prices outside the venture. Thus, this should not be an area of great concern.

Assessment

Where a network does not qualify for antitrust “safety zone” protection, it nonetheless should—if properly designed and implemented—be able to pass scrutiny under rule of reason analysis. This is true for both the analysis applied by the Federal Agencies under the Guidelines and as interpreted by the courts.

Particularly in the latter situation, a broad definition of what constitutes the relevant service market is likely to be employed. In either situation, the possible anticompetitive effects are more likely to be viewed as minimal if the venture is nonexclusive. Especially where there is economic integration through substantial financial risk sharing, the potential procompetitive effects may be significant in view of possible cost savings and other efficiencies. The network would hope to be able to demonstrate the latter inclusively once it has been in operation. Furthermore, significant anticompetitive effects stemming from ancillary agreements are unlikely.

Recommendations

In light of the risks, there are certain things physician controlled network joint ventures can do to enhance their legal position. Insofar

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as possible, they should attempt to position themselves for antitrust safety zone protection under the Guidelines by: (1) establishing and rigorously maintaining participation that is nonexclusive in fact; (2) limiting to 30 percent or less, in any likely relevant geographic market (using a twenty-five-mile radius as a rule of thumb), the number of participating physicians in a particular specialty with hospital staff privileges; and (3) focusing on either obtaining capitated contracts or, as to reduced-fee-for-service contracts, employing a 20 percent withhold of compensation devoted exclusively to inducing cost-containment and quality assurance.

At the same time, networks should buttress their position in terms of any rule of reason analysis that ultimately may be applied. If they exceed the 30 percent participating physician limitation applicable to nonexclusive arrangements, they should nonetheless limit the number of participants as much as possible to forestall any suggestion of market power. Further, networks should accentuate economic integration through substantial sharing of financial risk. Finally, they should strive to develop as soon as possible concrete data evidencing their cost-effective, efficient nature in the areas of cost containment (including administrative costs), utilization review, case management, quality assurance and economies of scale.

Conclusion

If properly designed and implemented, physician network joint ventures should be on solid legal ground in terms of antitrust considerations, as applied both by the Federal Agencies under the Guidelines and the courts under current case law. In that regard, a private suit may be more likely than an Agency challenge. This is so simply because, in this era of health care revolution, in a close case the Agencies seem more likely to pay deference to non-sham, good faith efforts to develop new health care delivery systems and leave it to the marketplace to sort out the winners

and losers. Yet, on substantive grounds, a network joint venture is likely to be better off in court than dealing directly with the Agencies. If litigation ensues, the relevant service market definition applied by the courts under rule of reason analysis should be even more favorable to the network than the stricter approach taken by the Agencies under the Guidelines.

NOTES

¹ See e.g., *Arizona v. Maricopa County Med. Society*, 457 US 332 (1982); *Colorado v. Colorado Union of Physicians & Surgeons*, 1991-1 Trade Cas. (CCH) ¶ 68,968 (D. Colo. 1990).

² See e.g., *FTC v. Indiana Fed'n of Dentists*, 476 US 447 (1986); *United States v. Greater Bridgeport IPA, Inc.* 1992-2 Trade Cas. (CCH) ¶ 50,741 (D. Conn. Sept. 30, 1992).

³ See bites 1 abd 2, supra; see also *In re Central Massachusetts Health Care, Inc.*, 1993-1 Trade Cas. (CCH) ¶ 70,186 (Mass. Sup., Suffolk Cty., March 3, 1993); *Massachusetts v. Cahill*, 1993-1 Trade Cas. (CCH) ¶ 68,118 (E.D. Wash. 1988).

⁴ *United States v. Alston*, 974 F.2d 1206 (9th Cir. 1992).

⁵ *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust* (US Dept of Justice & Federal Trade Commission, Sept. 27, 1994). The initial version of the Guidelines was issued by the Federal Agencies on Sept 15, 1993.

⁶ *Guidelines*, § 8 at 68-69.

⁷ *Id.* at 66.

⁸ *Id.* at 67.

⁹ *Id.*, §§ 8.A and B at 68-69.

¹⁰ *Id.*, § 8.B at 69-70. The Guidelines list five factors, as indicia of nonexclusivity: (1) current existence in the market of viable competing plans or networks having adequate provider participation; (2) actual participation or contracting by network providers in other plans or with other networks, or at least evidence of their willingness and incentive to do so; (3) earning by network providers of substantial revenues outside the network; (4) lack of indication of any significant de-participation from other networks in the market; and (5) lack of indication of coordination among network providers regarding price or other competitively significant participation terms in other plans or networks. *Id.*

¹¹ *Id.*, § 8.A at 68 n. 25.

¹² *Id.*, §§ 8.D.1-4 at 75-88.

¹³ See Graham, "Pueblo Merger Blocked - FTC Turns Down Big Hospitals' Deal", *The Denver Post*, Feb 1, 1994, at 1C, 4C.

¹⁴ E.g., *Indiana Fed'n of Dentists*, supra, note 2 at 461; *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 US 2, 7(1984); *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440, 1446-47 (9th Cir. 1988).

¹⁵ Of significance for states such as Colorado that have thinly populated areas, the Guidelines recognize that there may exist relevant markets with less than four or five physicians in a particular specialty. In such situations, the Guidelines provide that an otherwise-qualified network joint venture is not disqualified from antitrust safety zone protection if it includes just one individual physician (as opposed to practice group) from that specialty in locale, even though that will result in mathematically surpassing the applicable 30 percent (nonexclusive) or 20 percent (exclusive) threshold. *Guidelines*, •§§ 8.A and B at 68-69.

¹⁶ *Id.*, 8 8 at 70. The Guidelines do, however, indicate that the enumerated examples of capitation and withholding are not necessarily meant to be exclusive, and that the Federal Agencies will consider other, unspecified forms of economic integration amounting to the sharing of substantial financial risk. *Id.* Whether the economic risks discussed in the

General Fact Pattern would so qualify is open to question.

¹⁷ *Id.* at n. 27.

¹⁸ *Guidelines*, 8 8.D.1 at 75-76.

¹⁹ *Id.*, § 8.C at 71.

²⁰ *Id.*

²¹ Of course, if rule of reason analysis does not apply, the conduct would be subject to the harsher per se rule, which can have criminal as well as civil consequences. See notes 1-3, supra, and accompanying and following text. As a practical matter, both state and federal antitrust enforcement agencies and the courts might be more likely to apply per se rules to a physician joint venture where—because of the absence of substantial economic integration of the participating physicians' practices, due to lack of sharing in significant risk of financial loss—the arrangement appears designed to cloak the hard-core antitrust violation of price fixing. See, e.g., *Maricopa County Med. Society*, supra, note 1; *Alston* supra, note 4; *Colorado Union of Physicians & Surgeons*, supra, note 1.

²² *Guidelines*, § 8.C, Steps One-Four at 72-74.

²³ See e.g., *Smalley & Co v. Emerson & Cuming, Inc.*, 808 F.Supp. 1503, 1511 (D.Colo. 1992).

²⁴ See *id.*

²⁵ *Guidelines*, § 8.C, Step One at 72. As under the case law, the ultimate determination under the Guidelines may well be what health insurance plans and their subscribers consider good substitutes for the physicians participating in the joint venture. See *id.*

²⁶ See, e.g., *Smalley & Co.*, supra, note 23 at 1511.

²⁷ See, e.g., *id.*; *Guidelines*, § 8.C, Step Two at 73; § 8.D.3, 4 at 84, 87 (examples).

²⁸ *Reazin v. Blue Cross & Blue Shield of Kansas, Inc.*, 899 F.2d 951, 966-67 (10th Cir. 1990); *Westman Comm'n Co. v. Hobart Int'l, Inc.*, 796 F.2d 1216, 1225-26 n.3 (10th Cir. 1986).

²⁹ Market power is something less than monopoly power. See *Eastman Kodak Co. v. Image Tech. Services, Inc.*, 112 S.Ct. 2072, 2090 (1992). The two differ in degree, with monopoly power representing a "more stringent...standard," *id.*, constituting "substantial" market power". *Reazin*, supra, note 28 at 967 [citing *Areeda and Turner*, *Antitrust Law* ¶ 801 (1978)] The Tenth Circuit has noted that the lower courts generally recognize a 70 percent to 80 percent share of the relevant market as sufficient to indicate that an entity has monopoly power. *Colorado Interstate Gas Co. v. Natural Gas Pipeline Co.*, 885 F.2d 683, 694 (10th Cir. 1989). Thus, a market share substantially less than 70 percent could be seen as evidencing the existence of market power.

³⁰ Along with market share, courts determining the existence of and evaluating such power look to factors such as historical trends, the number of firms in the market, cross-elasticity of supply and demand, and the existence of barriers to entry into the market (in the form of legal requirements, economic practicability, etc.). See, e.g., *Reazin*, supra note 28 at 967-68 and n.23 [citing *Shoppin' Bag of Pueblo v. Dillon Cos.*, 783 F.2d 159, 162 (10th Cir. 1986)].

³¹ *Guidelines*, § 8.C, Step Two at 72-72; 8.D.3, 4 at 84, 87 (examples).

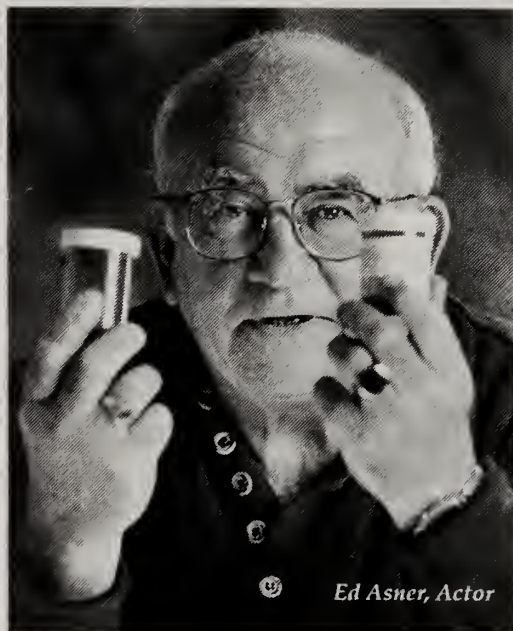
³² See note 10 supra, and accompanying text.

³³ *Guidelines*, § 8.C, Step Three at 73.

³⁴ *Id.*

³⁵ *Id.*

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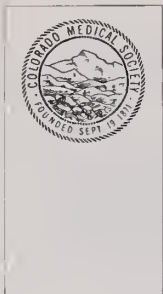


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Informatics Fair III— Sept. 28, 29

The Denver Medical Library Informatics Fair Committee has completed the final draft of the Fair's Lecture Series. Two Keynote Speakers scheduled for Thursday and Friday noon lectures are:

Michael J. Ackerman, PhD, currently the National Library of Medicine's Assistant Director for High Performance Computing and Communications. He holds an academic appointment as an Associate Professor in the Department of Computer Medicine at George Washington University.

Lawrence L. Weed, MD, a nationally recognized physician, and author of the problem-oriented medical record. Dr. Weed founded PKC Corp in 1982 and is professor of Medicine Emeritus at the College of Medicine, University of Vermont, and has held positions at the University of Pennsylvania, Walter Reed Hospital, Johns Hopkins Hospital, and Yale School of Medicine.

There will be a nominal registration fee for the Lecture Series. Call the Denver Medical Library for more information at 303-839-6670.

HVO sees record number of volunteers in 1994

Health Volunteers Overseas (HVO) set a new record last year for the number of medical professionals to volunteer in a single year. HVO is a private, nonprofit, international health development organization,

committed to improving the quality and increasing the accessibility of health care in the developing world through the teaching and training of local health care providers.

More than 225 health professionals volunteered for HVO programs during 1994, a 30% increase over the previous year and the largest increase since the organization's founding in 1986. Altogether, HVO has sent over 1,250 fully trained health professionals in the fields of anesthesia, dentistry, general surgery, internal medicine, oral and maxillofacial surgery, orthopaedics, pediatrics and physical therapy to more than 30 program sites in over 20 different countries throughout Africa, Asia, Latin America and the Caribbean.

Colorado physicians who have participated in the program during 1994 include Robert Eilert, MD, Tom Frierwood, MD, Richard Kemme, MD, Roger Sobel MD, Robert Derkash, MD, Thao Thi Thu Duong, MD, and Richard Fisher MD. There are currently openings at most sites, although some are already booked into 1997. Call HVO at 202-296-0928 for more information.

Preceptors needed for PA program

The University of Colorado Child Health Associate/Physician Assistant Program is seeking preceptors for PA students. Many physicians enjoy teaching the students and find that this is a good method of exploring the potential of PAs. The program is one of the oldest and most highly respected in the nation and the only

one is Colorado.

Students are placed in community pediatric and family practices one day every other week in the first year, then the clinical rotation time and scope increases in the second year to include surgery, two week summer rotations and rural practices, as well as once a week primary care rotations. Third year students are in clinical rotations full time and are required to complete rotations in primary care and electives. A new rural track places third year students in rural locations for up to four months. The family medicine curriculum has been expanded in recent years and graduates of this program pass the Physician Assistant National Certifying Examination at a rate higher than the national average.

If you want more information about becoming involved in medical education by precepting a PA, call Kathie Dolce at the UCHSC, 303-270-7964.

Alex Jones, MD Awarded Prestigious Fellowship

CMS member A. Alexander M. Jones, MD, FACS, is the recipient of the prestigious Cervical Spine Research Society Traveling Fellowship Award. During September, Dr. Jones will travel to London, Switzerland, Detroit and Seattle. He will be visiting with internationally recognized cervical specialists, learning the most advanced surgical techniques to share with his colleagues.



Dr. Jones, a graduate of Princeton and University of Virginia, completed his internship and residency in Orthopaedic Surgery at the Johns Hopkins Hospital. His recent research on multilevel cervical fusion shows how use of anterior plates — including titanium plates — does a better job of preserving the architecture of the neck with an improved fusion rate.

The Rocky Flats Citizens Advisory Board is looking for interested citizens

The Rocky Flats Environmental Technology Site northwest of Denver has decades of work ahead to clean up the environment and manage hazardous and radioactive materials. To increase involvement from those affected by the cleanup process, an independent Citizens Advisory Board (CAB) was formed in 1993. CAB provides policy and technical advice to the Department of Energy, the Environmental Protection Agency, and the Colorado Department of Public Health and Environment.

CAB is now accepting applications for new members

No special skills are required other than the ability to represent the views of one of the following groups: labor; environmental; area or regional residents; past or current Rocky Flats workers; academia; local

government; public interest; business community; or other affected groups. Our volunteer members are expected to commit about four hours per week to Board activities, including attendance at monthly Board meetings and active participation on one working committee. For an information packet and application, contact:

Rocky Flats Citizens Advisory Board Membership Committee, Ste. 2250

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Workers' Compensation Establishes Medical Treatment Guidelines

Medical Treatment guidelines have been established for physicians and health care professionals who provide medical treatment to Colorado's injured workers. The Division of Workers' Compensation, a regulatory office of the Colorado Department of Labor & Employment, has promulgated regulations as required by Senate Bill 91-218 for medical treatment guidelines for low back pain, upper extremity disorders (carpal tunnel syndrome and thoracic outlet syndrome), and lower extremity injuries to the hip, knee, foot and ankle. Colorado law mandates the development and use of medical treatment guidelines as a vital component to the state's ongoing efforts to provide consistent

and quality medical care for workers injured on the job, while controlling medial costs and utilization. The guidelines are now part of the Code of Colorado Regulations, 7 CCR 1101-3, Rule XVII, and are available to the workers' compensation community from the Public Records Corporation. Utilization standards are found in Rule XVI.

"The contributions of a wide cross-section of providers and carriers in the workers' compensation arena have made the formulation of these guidelines possible," says Barbara Kozelka, Director of the Division of Workers' Compensation. "Their efforts, as well as the extensive involvement of others in the workers' compensation community, have placed Colorado at the forefront in the national development of medical treatment guidelines." More guidelines are forthcoming as community task forces are presently developing guidelines". More guidelines are forthcoming as community task forces are presently developing guidelines for the treatment of cumulative trauma, shoulder injury and reflex sympathetic dystrophy.

Specific technical questions can be answered by Jacqueline Holmes at (303) 575-8798.



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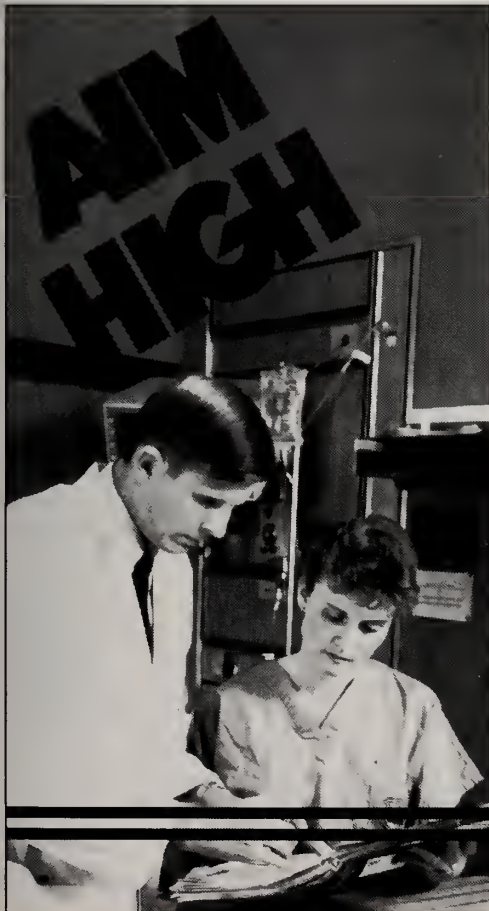
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RUMINATIONS

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by **Bill Pierson**, Managing Editor

Excerpts from the *Journal of the Royal Society of Medicine* Volume 83 November 1990

We can learn a lot from *Ovis canadensis*



I've always had a great admiration for the Rocky Mountain Bighorn Sheep and a comparable respect for researchers in a variety of fields. I've watched the sheep in Colorado a lot, since they're all around my house (even in my yard). I've never watched researchers, but can see them by their work. A particular paper* published in the *Journal of the Royal Society of Medicine* caught my attention as it brought together the two: bighorn sheep and research scientists.

The report commenced by saying: "Over a million injuries caused by slipping of footwear are believed to require treatment by doctors every year in the United Kingdom and many domestic animals are injured by slipping.

Recent research has revealed that surface roughness of solings and floors is an important determinant of grip on lubricated surfaces and it is also known that soling friction is affected by hardness. The bighorn sheep (*Ovis canadensis*), an animal species which has adapted to a slippery environment, was studied to elucidate optimum roughness and hardness and other features which influence grip. Four adult ewes were examined in the London Zoo. The cloven hooves of this species are very mobile and the cranial tips of the hooves are the first parts to make contact with the ground.

A very small contact area ensures penetration of a film of water. Further studies of the feet of wild species could contribute to an understanding of the factors which determine the safety of solings and floors."

The paper continues "Slipping accidents commonly cause fractures, injuries to the lumbar spine and disproportionately more disability than other common accidents. It is also known that many domestic animals are injured by slipping".

This research project was about understanding how nature provided many of the animal kingdom with slip-resistant feet, of which the bighorn is a classic example.

Previous research into human falls indicated that the most dangerous slips occur on heel strike. "This study found that the average angle between heel and ground on contact is 21°. Due to the forward momentum of the foot, any liquid on the ground is wedged under the tip of the heel, preventing contact, in a

similar manner to aquaplaning of tyres on a wet road."

Observations of "A thriving flock of bighorn sheep in the London Zoo (Zoological Society of London), led to the following hypothesis. The bighorn sheep's feet have a narrow contact area and the cranial tip of the hoof is the first part to make contact. This ensures immediate penetration of any film of water and perhaps also of mud, moss and lichen. As the hooves spread apart with increasing weight, the narrow outer contact areas act like scrapers to clear contaminants. The contact area is relatively rough and the microscopic projections, known as asperities, interlock with those on the rock and forward motion is arrested. By contrast, the heel of a human foot is the first part to strike the ground and any fluid on the surface acts like a wedge if the heel continues to move forward; contact with the ground may be prevented, causing a slip.

The authors conclude their lengthy research by stating: "The puzzle of what determines secure underfoot grip is gradually yielding its secrets. Much more could be learned from studies of adaptation by animal species to various environments. Research on underfoot friction is an exciting intellectual challenge".

***Slip-shod or safely shod: the bighorn sheep as a natural model for research.**

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- This certificate and the car rental pursuant to it are subject to Alamo's conditions at the time of rental. Minimum age for rental is 21. All renters must have a valid driver's license.
- The maximum value of this certificate which may be applied toward the basic rate of one rental is \$10 OFF in the U.S.A. or 5% OFF in Europe*. The basic rate does not include taxes and other optional items. Valid on self-drive rentals only. No refund will be given on any unused portion of the certificate. Certificate is not redeemable for cash.
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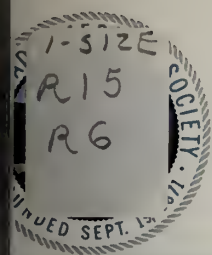
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COLORADO MEDICINE

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Volume 95, Number 10

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Joel M. Karlin, MD
125th President
Colorado Medical Society

This Issue:

- The Doctor-Patient Relationship** Joel M. Karlin, MD
Informed Consent from the other side of the desk Page 350
CME: Are you learning anything? Page 352
Medicaid Rejections (What's the problem?) Page 360

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COLORADO MEDICINE

October, 1995

Volume 92, Number 10



Cover Story

After one hundred twenty five years, it's still a thrill to see a new President installed. Find out what he had to say on page 343.



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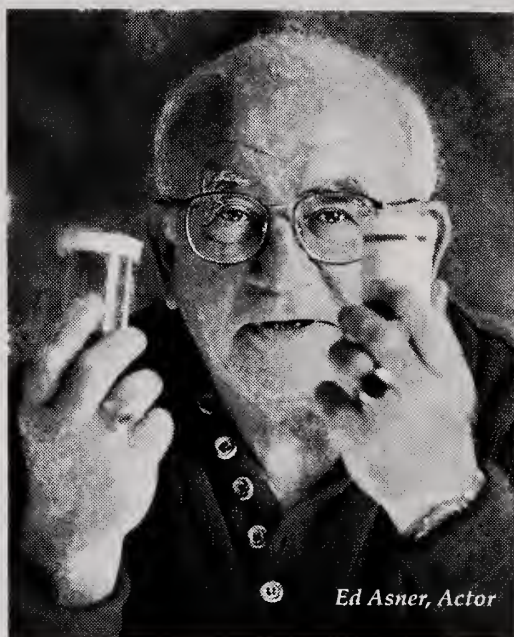
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Attention: Physicians



Ed Asner, Actor

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...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

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by **Montgomery Little and McGrew, P.C.**

legal counsel to the Colorado Medical Society

Answers to CLIA Questions Available by FAX from COLA

NOTE: In Resolution 77-P from the 1994 Annual Meeting, the House of Delegates directed that the CMS publicize the Commission on Office Laboratory Accreditation as an alternative to CLIA 88 federal certification for accreditation of physician office labs. Following is some information which should be helpful in that regard.

Brief but comprehensive information on commonly asked office laboratory questions and the CLIA '88 regulations is now immediately available free of charge via same-day FAX to physicians and their staffs through the Commission on Office Laboratory Accreditation (COLA). This unique service, made possible through a cooperative agreement with the Centers for Disease Control and Prevention (CDC), is available by calling COLA Customer Service toll-free at (800) 298-8044.

"This new service augments the phone support already provided by the COLA Customer Service Center, a high-tech phone center professionally staffed with medical technologists," says Doug Beigel, COLA Chief Operating Office. "CLIA Facts Sheets will be FAXed the same day to any physician or laboratories inquiring about a number of office laboratory-related topics." The single topic CLIA Fact Sheets condense information from a variety of voluminous sources, such as the Federal Register and laboratory manuals, into a user-friendly, one-and two-page format. There are 33 Fact Sheets covering such topics as Quality Assurance, Quality Control, Proficiency Testing, OSHA, personnel standards, CLIA, and other laboratory requirements. The complete list includes:

1. How to Register Your Laboratory for CLIA Purposes
2. How to Find Out More About Your Laboratory's State Licensure Law
3. Seeking Accreditation from a HCFA Approved Accreditation Program
4. How to Properly Register Your Shared Laboratory with HCFA
5. How to Get a Copy of the CLIA Regulations
6. Requirements for Provider-Performed Microscopy Procedures
7. How to Change Your CLIA Certificate
8. Notification and Requirements and Other Responsibilities to HCFA
9. Writing a Procedural Manual
10. Proficiency Testing Information
11. What Every Laboratory Should Know About Documentation
12. Quality Control for Moderate Complexity Testing
13. Quality Control for High Complexity Testing
14. Remedial Actions
15. Quality Control for Microbiology
16. Quality Control for Hematology and Immunohematology
17. Quality Control for Immunology
18. Quality Control for Mycobacteriology, Mycology, and Virology
19. Quality Control Requirements for Blood Gas Analysis and Drug Test Screening
20. A Possible Way to Manage Quantitative Quality Control Results
21. Calibration and Calibration Verification Procedures

Continued following next page...



Med Fax: Medico-Legal News

*by David A. Burlage, Esq.,
Shareholder, and Karen B. Best,
Esq., an Associate with the law firm
of Montgomery Little & McGrew, PC.*

*This column is not legal advice, but is for general
information only. For help with specific problems,
readers should consult an attorney.*

This is the first of two articles concerning sexual misconduct as a grounds for professional licensing board action.

"...I WILL COME FOR THE BENEFIT OF THE SICK, REMAINING
FREE OF ALL INTENTIONAL INJUSTICE, OF ALL MISCHIEF AND
IN PARTICULAR OF SEXUAL RELATIONS WITH BOTH FEMALE
AND MALE PERSONS..."
HIPPOCRATIC OATH

Introduction

The prohibition against sexual contact between a physician and a patient has long been established as a principle of ethical behavior for physicians. The rationale for this prohibition is an awareness of the adverse effects that physician-patient sexual contact has on the patient. These include humiliation, feelings of mistreatment and exploitation. Regulating agencies and licensing boards are taking an increasingly stronger stand against physicians, psychologists and other health-care professionals who exploit patients sexually.

The patient has a right to trust that a physician or other health-care provider will always act in the patient's best interests. The introduction of sexual behavior into the professional relationship violates this trust. The physician's personal interest competes with the best interests of the patient. The violation of trust may produce negative psychological consequences for the patient. Moreover, the violation of trust destroys public confidence in the profession.

In most situations of physician-patient sexual contact there is a disparity of power and authority coupled with a physically or emotionally vulnerable patient. When boundaries are violated the patient is victimized. The physician must set the boundaries between compassionate care and the emotional responses which may lead to sexual misconduct. Failure to do so constitutes unprofessional conduct which will subject the physician or other health care provider to discipline by the appropriate licensing board sufficiently severe to insure that the public is not at risk for recurrence of the misconduct.

Description of Professional Disciplinary Boards

Art. IV, Section 22 of the Constitution of Colorado provides that "[A]ll executive and administrative offices, agencies, and instrumentalities of the executive department of state government and their respective functions, powers, and duties ... shall be allocated by law among and within not more than twenty departments..." The Administrative Organization Act of 1968 (§ 24-1-122 CRS) created the Department of Regulatory Agencies. The executive director of the Department of Regulatory Agencies is appointed by the Governor, with the consent of the Senate, and serves at the pleasure of the Governor as one of the members of the Governor's cabinet. The Division of Registrations and the Board of Medical Examiners, which oversee the registration and licensing of physicians, operate within the Department of Regulatory Agencies [§ 24-1-122(2)(g)].

Powers of the Boards to Revoke or Suspend Licensure

The Board of Medical Examiners has the power of summary suspension (§ 24-4-104(4)) CRS). "Where the agency has reasonable grounds to believe and finds that the licensee has been guilty of deliberate and willful violation or that the public health, safety, or welfare imperatively requires emergency action and incorporates such findings in its order, it may summarily suspend the license pending proceedings for suspension or revocation which shall be promptly initiated and determines." Other powers of the Board of Medical Examiners, and other licensing boards (for Accountants, Architects, Chiropractors, Dentists, Pharmacists, Nurses, and others) are found in each board's enabling statute. These powers may include the power to adopt and promulgate rules and regulations; the power to make investigations, hold hearings and take evidence; the power to subpoena witnesses to administer oaths, to compel testimony of witnesses, and to compel production of documents. Finally, each board typically has the power to aid the district attorneys of this state in the enforcement of the enabling statute and in the prosecution of all persons, firms, associations, or corporations charged with the violation of any provisions of the statute.

Next month: Sexual misconduct as a form of unprofessional conduct; disciplinary sanctions; injunctive powers of the Board; public disclosure of board investigations and actions; administrative procedures; ethical considerations; and regulatory developments.

CMS Med Fax

Answers to CLIA Questions Available by FAX from COLA

(from page one...)

- 22. Safety Standards
- 23. OSHA Standards for Bloodborne Pathogens
- 24. Meeting the Personnel Standards of Moderate Complexity Testing
- 25. Meeting the Personnel Standards for High Complexity Testing
- 26. Grandfathered Laboratory Directors
- 27. Responsibilities of the Laboratory Director
- 28. Grandfather Provisions for the General Supervisor
- 29. New Pathways to Quality as the General Supervisor and Testing Personnel for High Complexity Testing
- 30. Quality Assurance in the Laboratory
- 31. What to Expect During Your CLIA Inspection
- 32. How to Respond After Your On-Site Survey
- 33. CLIA Sanctions and Procedures for Appeal

COLA is a not-for-profit, physician-directed education and accreditation organization for the office laboratory. A national organization with more than 8,300 participants in its accreditation program, COLA was founded in 1985 and incorporated in 1988. COLA's program is approved by the Health Care Financing Administration (HCFA), and COLA-accredited labs are recognized as meeting all CLIA requirements.

Sponsored by the American Academy of Family Physicians, American Medical Association, American Society of Internal Medicine, and College of American Pathologists, COLA is also endorsed by the American Osteopathic Association and over 25 state medical and specialty societies. For more information, contact the COLA Customer Service Center at (800) 298-8044.

Daily Medicare Updates to be posted on toll free hotline

As a service to the Federation and the AMA membership, the Division of Political and Legislative Grassroots, in cooperation with the other Divisions in the Washington office of AMA, will be updating the toll free Legislative and Grassroots Hotline regarding the

Medicare debate in Congress. Each report will include the latest information from Capitol Hill as well as specific AMA/Federation action items.

The phone number is 1-800-833-6354.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Long-Term Care Advisory Meeting

Regular monthly meeting

October 10, 1995, 10 am

4300 Cherry Creek Dr S, Denver, CO

Jeanne-Marie Bakehouse, 303-692-2887

Colorado Water Quality Control Commission

Informational hearings on water quality regulations

October 10, 11, 1995

4300 Cherry Creek Dr S, Denver, CO

Diana Glaser, 303-692-3525

Hazardous Waste Commission

Colorado Hazardous Waste Rulemaking hearing

October 17, 1995

4300 Cherry Creek Dr S, Denver, CO

Laurie Simmons, 303-692-3325

Colorado Board of Health

Regular monthly meeting

October 18, 1995

4300 Cherry Creek Dr S, Denver, CO

Laurie Maldonado, 303-692-2035

Radiation Advisory Committee

Proposed regulations

October 18, 1995

4300 Cherry Creek Dr S, Denver, CO

Michelle Sims-Moore, 303-692-3034

Colorado Springs Osteopathic Foundation

The Just Allocation of Scarce Resources

October 19, 1995

Colorado Springs, Colorado

719-735-9057

Air Quality Control Commission

Oxygenated Fuels & Radionucleides

October 19, 1995

4300 Cherry Creek Dr S, Denver, CO

Janet Lenger, 303-692-3100

Equity Management Systems

Winning the Investment Game

October 19-21

Scottsdale, AZ

800-257-2216

Advisory County on Adolescent Health

Mental Health in school-based health centers

October 20, 1995

4300 Cherry Creek Dr S, Denver, CO

Nancy Griffith, 303-692-2326

Joint Commission on Accreditation of Healthcare Organizations

8th Annual National forum on Health Care Quality

November 8-11, 1995

Chicago, IL

708-916-5800

International Meniere's Disease Research Institute

7th Annual Interdisciplinary Seminar on Diagnostic and Rehabilitative Aspects of Dizziness and Balance Disorders.

December 6-10, 1995, Denver, CO.

Contact: Jane Wells or I. Kaufman Arenberg, MD.(303)778-4235

American Brachytherapy Society

Annual Mid-Winter meeting

"Brachytherapy: The First Hundred Years"

December 10-13, 1995

Hyatt Regency Scottsdale, AZ.

Contact: (215) 574-3158

American College of Cardiology

The 27th Annual Cardiovascular Conference at Snowmass(1617)

January 15-19, 1996

Snowmass,Colorado

Contact: 800-257-4739

American Diabetes Association—Colorado Affiliate

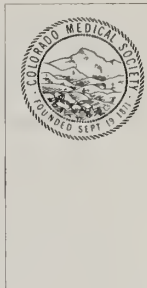
32nd Annual Colorado Diabetes/Endocrine Institute

January 20-25, 1996

Aspen-Snowmass, Colorado

Contact: Becky Burtis 303-778-7556

PRESIDENT'S LETTER



Joel M. Karlin, MD
President, 1995-1996

Inaugural speech delivered Saturday, September 9, 1995, at the 125th Annual Meeting of the Colorado Medical Society, Aspen.

"The Doctor-Patient Relationship"

This year I celebrate 21 years in the private practice of medicine. My career choice became clear when I was very young. The relationship of trust and caring my family enjoyed with our general practitioner was a strong factor in the life of an eight year old boy, growing up in New York City. My parents taught me that if I worked hard, put in that extra effort in school, and worked to develop that same understanding my family doctor demonstrated for the problems of others, someday I might become a doctor, too. Many of us had similar teachings by our parents.

And the ability to practice medicine "used to be" that way. Do a good job for patients... be available to them and other doctors... practice high quality medicine... and charge a reasonable fee... a prescription for success. That was at a time when each of us knew what was expected of us, and the patient and their referral doctors made the choice of physicians.

That was at a time when the patient and the physician had control of the health care delivery system. That was 21 years ago.

The value I learned most, from our family doctor of over 20 years, was the value of the doctor-patient relationship. It is the cornerstone upon which our American health care system has been built. Over the years, Dr. Lou Orens was there for the needs of both my family and me. He cared for everything from the sprained ankle I suffered while playing Little League baseball, to my badly cut elbow I received when I learned my new bike had the brake on the handles and not the pedal, to

a prolonged bedridden illness in high school which turned out to be infectious mononucleosis, and not leukemia as first feared. He provided both the medical and emotional support for our family. He was my cheerleader, who continually urged me to enter medicine as my career, my chosen profession.

And so I did. And that is the second best decision I ever made. For, over the years, I learned the value of the doctor patient relationship from the other side, the side of the physician. Let me share with you the stories of two patients, whose lives I have helped, in ways similar maybe to the way Dr. Orens helped my family and me.

Michael was a 12 year old boy when I first met him, who badly wanted to play football. But Michael had asthma, and although physically big, his disease limited his performance. So Michael, his mother, and I, began to work together as a team. During his evaluation we identified those factors which triggered his asthma. Then we began a course of treatment directed at each trigger. Michael and his mother modified his home environment, began a comprehensive medication and monitoring program, and came weekly for allergy injections. Within a short time, Michael was successfully competing in football, unhampered by his asthma. Within two years Michael was off medication, and within four years no longer required allergy injections. Michael went on to graduate all-state defensive end

Continues

from his high school in Arvada. He attended Notre Dame and played football on scholarship for 4 years. He graduated first team All-American. He was a first round draft choice in the NFL, where he played for several years. Michael grew to be 6 foot, 6 and 280 pounds. Never again would asthma be a significant factor in his life.

Shirley, on the other hand, was in her early 80s when we first met. She had moved to Colorado from New York to be near her daughter. While living in a retirement facility in Denver, Shirley, her daughter and I have worked hard to control her asthma and improve the quality of her life. Sharp as a tack mentally, Shirley had other medical problems with which to deal. Early on, I referred her to an internist who shares similar patient values, and with her help, we have seen Shirley through pulmonary emboli, thyroid cancer, and the inevitability of aging. Recently, Shirley, dressed radiantly, and her daughter, joined me for lunch to celebrate Shirley's 90th

birthday. I hope that I will have many more opportunities to celebrate birthdays with Shirley.

It's hard to put my finger on exactly what these two doctor-patient relationships mean - relation-



Dr. Joel Karlin following his inaugural address, saying "It's all about physician-patient relations".

ships of caring, trust, mutual respect, and emotional support. They mean so much to both me and my patients.

But, the many changes in the health care marketplace have frequently eliminated the ability of a patient to establish and maintain that desired doctor-patient relationship. Many of the problems that have put the doctor-patient relationship in jeopardy can be traced to the creation of our third party payer system, where someone else chooses and pays for our health care. During World War II, a time of wage and price controls, employees were given the tax-exempt benefit of health insurance in lieu of additional wages. During the '50s, '60s, and '70s, employee groups and unions bargained for additional health benefits, often first dollar coverage. Although such coverage provided immediate economic benefit, it soon sheltered the employee from the costs and consequences of their decisions to consume health care. Combined with rapidly advancing medical technology, the costs of treating social diseases, such as alcohol and drug abuse, teen pregnancies, and victims of crime,

LEGAL UPDATE

*from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000*

I'm Scheduled for a Deposition: What is Expected of Me?

Of utmost importance, maintain your integrity and professionalism. Do not be an advocate for your patient. Remember you are the professional health care provider.

It is very important to work out payment arrangements prior to your deposition. Confirm all arrangements in writing and obtain payment from the appropriate parties prior to your deposition.

You will need to know your patient's current and past medical history. Review all your records and any records prior to your involvement, as well as all insurance, medical, chiropractic and dental examination records.

Speak with your patient regarding the details and specifics of the incident or accident that caused the dispute and/or injury.

Does your patient believe that the treatment is working? Is he/she getting better? Can you objectively quantify improvement? These are questions you need to ask yourself when preparing for a deposition.

Also ask yourself, as you will likely be asked: What are your short- and long-term goals? When will the patient independently control his/her recovery? Was the care you rendered curative or palliative? Are there psychological issues impeding or assisting your patient's recovery? When do you think your patient will reach maximum medical improvement? Will there be permanent residual problems?

Communicate with your patient's attorney prior to your deposition. This is important so that you can be apprised of the status of the case. Many cases

deal with issues of pre-existing conditions or predisposition to an injury and, therefore, apportionment is important.

At the deposition, remember —

- Tell the truth
- Be objective
- Don't testify beyond your expertise.
- Be loyal to your profession and yourself, not to who asked you to give testimony.
- Answer questions clearly and concisely. Don't ramble or "preach".

For further information, please contact:

Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling, P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

and an ever-aging population, the rate of rise in the cost of health care grew at a rate of more than double national inflation.

Something had to give. If the resources to pay for health care were not infinite, then either the system had to restrain how much was paid per procedure, or restrain the number of procedures provided. The outcry came from the purchasers of health care: the employers (often through private insurance companies) and the government, at a time when individuals were paying proportionately less for the care they received. In 1960, individuals paid 49% of their health care costs, while government programs paid 24% and insurance companies paid 22%. Contrast this with the 18% individuals paid, 44% the government paid, and 34% insurance companies paid in 1993,

Such was the advent of managing care. Try to provide only "necessary care", at a lower cost. The problem has been to define "necessary care". What may be necessary from the patient's viewpoint, may not be necessary from the viewpoint of the one who pays for the care.

Herein lies the problem. The employer tries to manage the cost of providing health insurance to employees, while the employee may not be able to choose the desired services, health care delivery system, or physician. Often, the employee has so little involvement in the system, that they do not respond to normal market forces. Globally, market forces may have slowed the rise in cost of health insurance, but often in ways undesirable to patients.

The Colorado Medical Society, in recent years, has addressed the plight of patients and their physicians on two different fronts. Equipped with an excellent staff and many dedicated physicians, CMS has engaged in a pro-active, progressive approach. The first strategy was to affect positive changes in the current system. As advocates for our patients and the high quality care they deserve, we have insisted at the State Legislature that only physicians be

allowed to practice medicine.

This year we collaborated with nurses and physician assistants to provide those mid-level providers limited access to patients, but only for specified indications and in collaboration with a physician. We opposed the expansion of services provided by naturopaths, acupuncturists, and far eastern oriental medicine "persons". Last month, with the excellent help of Drs. Dick Allen and Howard Netz, we were able to persuade the Sunrise-Sunset committee of the state legislature not to



Joel and Caroline Karlin and the first dance at the President's Inaugural, "Puttin' On The Ritz", Saturday evening, September 9th, Ritz-Carlton.

expand the scope of practice of pharmacists-- another group who would like to practice medicine. We must continue to be watchdogs for quality health care for our patients. Let the message be clear. If you want to practice medicine, there is a way-- graduate from medical school and obtain a medical license.

On another note, a few years ago managed care companies determined that it would be more efficient to limit the number of physicians in their plans. Overnight, many physicians began to receive letters of termination without cause from insurers. Unfortunately, some physicians have been inappropriately deprived of access to patient groups based on unknown standards and microanalysis of incomplete global data. I am convinced that when physicians know the standards by which they are judged, almost always they will adhere to those standards to the benefit of their

patients and themselves. But, such an assumption is based on the setting of fair standards known to the physician, and the collection and appropriate interpretation of data from which a physician can be judged. Limited by the contractual language in their managed care participation agreement, often such physicians have little recourse, and their patients lose the ability to see their physician.

Leaders in Colorado Medical Society worked for over two years, beginning at the CMS Physician Patient Advocacy Council, to develop a program to restore access to patients and fairness to physicians.

On January 13, 1995, Friday the 13th, at the CMS Board of Directors meeting, Dr. David Martz, CMS President, signed "The White Paper on Physician Affiliation/Disaffiliation" which had been signed earlier that day by Mr. Mark Donohue, President of the Colorado HMO Association. This paper, the first of its kind in the United States, culminated one year of every other week negotiations between the Colorado HMO Association and Dr. Bob McCartney and myself, representing CMS. The document assures participation in the joint program by Colorado HMOs representing at least 80% of the covered HMO lives in the state. It should take the mystery out of the process of affiliation/disaffiliation of physicians by HMOs, and instill a system of fairness for physicians. In recent weeks, I have had discussions with three other HMOs which I believe will sign on before the end of the year. The "White Paper" has led to the creation of an ongoing CMS/CHMOA committee to discuss issues of mutual concern. Recently, one Colorado HMO asked for our assistance in "downsizing" their specialty panel. We were able to suggest mechanisms which would promote continuity of care, best serve the patients and physicians so affected while preserving the right of the HMO to restructure their physician panel. More recently, we were made aware that the National

Rehab News

NovaCare — At the forefront of the rehabilitation industry

NovaCare Outpatient Rehabilitation, formerly Therex Physical Therapy, provides an array of physician therapy services. They include orthopedic physical therapy, hand therapy and aquatic therapy. Our therapists average eleven years of professional experience and are dedicated to continuing education and professional growth. We pride ourselves in the establishment of treatment goals that include restoring the patient to maximum post-injury function and in the use of a team approach between physician, therapist and patient. Information and ideas are shared to accelerate progress toward mutually-based goals.

In addition, to help combat escalating worker compensation costs, NovaCare Outpatient Rehabilitation has implemented a proven approach to reduce workers' compensation costs while promptly and safely returning workers to the job. The program is called Work Injury Network/WIN®.

The goal of the WIN® program is early identification and prevention of problems before they occur. WIN® is based on a proven, progressive philosophy that treats injured workers like "industrial athletes" by using a sports medicine approach to care. From day one, the injured workers are involved in their own rehabilitation process by learning the mechanism of injury, proper work postures and contribution to their own care.

We offer 7 convenient locations and extended hours as well. For more information about our services and progressive treatments, please contact Vanessa Lewis-DeBoer or Marc Schneider at 303-696-6566.

NovaCare, Inc., is the leading rehabilitation management services company in the United States and is the nation's largest employer of rehabilitation professionals.



NovaCare
Outpatient Rehabilitation
(303) 696-6566

Association of State Insurance Commissioners have included the principles of the "White Paper" in their health reform package to be presented as both suggested national and state legislation and regulation.

Working within the system, CMS, over 2 years ago, began to explore the feasibility of developing a physician-directed managed care entity where the patient's interests were paramount. After discussions through committees and task forces and utilizing the input of a statewide CMS member survey, last year you created Colorado Physicians Network, or CPN. CPN hired a knowledgeable and talented consultant in David Ginsberg, whom many of you heard at this year's educational program. Together, they determined to find a joint venture partner who shared the core values of CPN, which are:

1. Patients are precious.
2. Physicians are precious.
3. Provide a greater role for physicians in managed care administration.
4. Improve physician access to patients, and patient access to physicians.
5. Promote administrative efficiency.
6. Use positive reinforcement and incentives for physician behavior modification.
7. Implement fair data collection and interpretation systems.
8. Promote fiscal responsibility.

Last month, CPN selected Rocky Mountain HMO as their partner. Hopefully, you have learned at this meeting about our product which we plan to have in the marketplace in early 1996. Over the next 3 months, CPN will build a statewide physician organization. During this open enrollment period, all credentialed Colorado physicians will be given an opportunity to join. CMS members will be given special financial consideration. CPN will be A NONPROFIT company governed by a Board consisting of equal primary care and specialty physician representation. The schism that has been fostered among physicians by previous proprietary interests in

health care must be eliminated. Regionally based utilization management will be performed by physicians around the state. Already formed physician groups and organizations will be encouraged to join as potential risk-taking entities. A new generation of managed care will be developed by providing a continuum of care performed in the most appropriate setting with primary care and specialty physicians working together.

We want to set a standard by which other managed care companies will be measured. Over the next 4 weeks, Dr. David Martz, Dr. Jack Berry, and I will be traveling around the state, meeting with physicians to solicit their participation. We need your active support to be successful. This may be our one chance in our lifetime to truly change the course of health care delivery in Colorado. Let's not lose this opportunity.

The second front on which your medical society is working looks at fundamentally changing the health care delivery system itself. So many of the current problems can be corrected by putting the patient in control of the system. In such an ideal system, the patient would become a health care consumer. The patient, not their employer or government, would select the delivery system and plan, which best meet their personal needs. In such a system, quality, cost, and access would determine the winners. Although multiple funding source would be used, in the end the patient would be in control. As a first step, we have begun working with major players in the state to reform the individual health insurance market in Colorado. It has become clear that if we want the patient to take charge of the system, then we must educate them to make informed choices. I see CMS working with employers, patients, and state government in a cooperative venture to provide such education. Additionally, with the recent demise of the Colorado Health Data Commission, your leadership has begun working with our CMS Data Committee to look for ways we can prepare

ourselves to participate in future data initiatives. If we are to empower the patient to choose the delivery system, health plan, and physician, we must participate in making meaningful data available to assist in their choice. A young couple in their 20s, expecting their first child, should be given the information informed consumers would need to make their choice. But it must be done the right way. Too many physicians were inappropriately hurt when some HMOs early on assembled and tried to interpret data. We must learn from their errors and adjust for population demographics, scope of services, severity of illness, co-morbidity factors, outcomes, and a never mentioned factor--quality of life. No longer is it acceptable for the Colorado Medical Society to sit back while others decide the fate of our patients and physicians. CMS will work to be at the table and participate constructively in all health care initiatives.

To promote patient choice, CMS introduced, as a first step, our Point of Service bill into the last legislative session. Although we lost by the narrowest margin of 1 vote in the House Appropriations Committee, we did a lot to educate the legislators, the governor and his staff, and the employers, on the issue of patient choice. **My Doctor, My Choice** became our slogan at the State capitol. Out of our efforts grew the desire for employers to sit down for the first time ever with physicians to discuss ways to improve our health care delivery system. The Focus Group on Health Care Issues on which Drs. David Martz and Dick Allen sit, and I chair, has been meeting every 2 weeks. We are openly discussing these issues, and with the help of the business community, will work towards positive change. As has become our style, we will negotiate what we can, and potentially develop a joint legislative proposal addressing the rest.

As you are aware, both Medicaid and Medicare are social programs which cannot be sustained in their current forms. Medicare will go broke in the year 2002 if left untouched. Medicaid, a program to

fund care for the poor, has become the largest budget item for many states. Your Colorado AMA Delegation participated in developing a proposal for a privatization system, based on patient choice, which has been forwarded to the Speaker of the House. Medicaid may become a block grant program which presents many challenges and opportunities. I plan to ask our Health System Reform Task Force to work on these issues.

I recently participated as part of the faculty for the Montgomery Dorsey symposium, where gurus in health care policy, such as Victor Fuchs, Robert Reischauer and Uwe Reinhart, predicted continued changes in the way we provide care. Their future included physicians, not insurance companies, in charge of



Dr. Karlin (l) in his first official act presenting outgoing president David Martz with the CMS Certificate of Service for his efforts on behalf of CMS during his term.

the delivery system, and the elimination of employer control. If ever there was a need for physicians to work together for the preservation of their profession and the well-being of their patients, that need is quite apparent now.

That eight year old boy from New York City has grown up now. He just wants to be sure that his daughter, Bethany, who wants to become a doctor, will have the same opportunity he has had, to experience that special feeling that makes being a doctor so special, the doctor-patient relationship.

A heartfelt thank you to the wonderful CMS staff who recognize that change is essential if we are to fulfill our mission, even if it means some 6:30 AM meetings, to the CMS Board of Directors who have al-

lowed Dr. Martz and me to test uncharted waters, to our Council and Committee Chairpersons and members for their work this year, and to all of you who will be asked to help us this year as we regain control of our health care delivery system. And thank you, David Martz, for allowing me to take such an active role this year as President-elect. I hope this year will begin a tradition. For two energized leaders can accomplish a heck of a lot.

Let me close with a final story. It was a very hot day, in the 90s. The sun was shining down strongly. A young woman was walking along the shore in Maine, when all of a sudden, a huge wave crashes into the shore, washing on to the beach thousands of star fish. The woman bends down and begins tossing the star fish one by one back into the ocean. A man walking along the shore sees the woman doing this, stops, and asks the woman, "Why are you doing that? With all the thousands of star fish on the shore, you couldn't possibly toss enough star fish back into the ocean to make a difference". The woman bends over, picks a star fish off the beach, and replies to the man, "Do you see this star fish?" at which time she tosses the star fish back into the ocean, looks up at the man and adds, "To that star fish, it meant all the world". Sometimes, we think that what we do doesn't make a difference. But it really does.

Thank you. I very much look forward to being your President for this coming year.



EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society

"... physicians are human too."

Your Colorado Medical Society recently completed its 125th Annual Meeting. For me, I have been a part of ten Annual Meetings. Doesn't seem possible that I have been at CMS for that length of time.

What have I learned? I have learned that physicians are human beings too. Most of the general public think of physicians as invincible. You don't get sick, you never make mistakes. Physicians are held to a much higher standard than other professionals.

One can't work ten years for an organization without making some very good friends. Over the past four years, I have seen three members of CMS go through some very troubling times. These three physicians are close acquaintances of mine and it struck me very hard when I found that they indeed were human, with very real problems.

Two of these friends have gone through a divorce, dissolution of their medical practice, and completed alcohol rehabilitation. I can't imagine how difficult it is for a physician to admit to a drinking problem. The stresses of everyday life are different now than they were ten years ago. Life itself is more stressful. For physicians, this is compounded by an uncertain future and ever-changing medical practice environment. Does the fact that these two physicians have admitted to a drinking problem make them any less of a person? No, it does not. They are still compassionate and knowledgeable and caring individuals. But, where do these physicians go from here? They can't

practice medicine - something they miss terribly. Should CMS, along with the Colorado Physician Health Program and the Colorado Personalized Education Program for Physicians develop a program to help displaced physicians? I'd like input from you on this, please.

My third friend has been a long-time member of CMS. He had recently been diagnosed with cancer. My friend doesn't let his illness slow him down. He still maintains a full patient load and would have it no other way. Physicians deal with life and death in a way that I never could. It still saddens me when I think of what my friend is going through. When I think about him perhaps not being around for next year's Annual Meeting, I get tears in my eyes. None of us is very good at saying how we feel, until it is too late. I refuse to let this happen. When he reads this he'll know who I'm talking about. He is a wonderful person. I want him to get better but, realize he may not. He has been a good friend for many years. I need him around as my "reality check". No, the voice of reason he always is not, but his heart is always in the right place. If only I could be as courageous as he. He has always been there for me over the past ten years. I am now here for him.

Yes, physicians are human too. In this day of high competition between physicians and all the outside forces threatening your practice — remember to be kind to each other, for who knows what unfortunate event may strike tomorrow.

THE PAC MOVEMENT



by Robert B. Sawyer, MD
Chairman, COMPAC

What is it?

"IT" is the Colorado Medical Political Action Committee, and it's story is told in most eloquent terms by a 1968 editorial piece in the Rocky Mountain Medical Journal (Oct. '68, Vol. 65, #10:16) by the then COMPAC Chairman, Francis T. Candlin, DVM.

Here it is October, 1995, and Dr. Candlin's statement is every bit as true and even more important.

The greatness of medicine in this country is an acknowledged achievement throughout the free world. It was accomplished by a united effort of every responsible agent—the physician, pharmacist, and researcher on one hand and the drug industry and our hospital and educational systems on the other. Only a free economic system made it possible. Basically we are all entrepreneurs in this highly competitive society and our inter-dependency becomes more apparent each day. We all demand freedom of choice from our clients and freedom of thought in our actions.

To preserve this unique system from perennial attacks so prevalent in our country today, medicine decided that some form of a political action committee would be necessary, and so AMPAC, the American Medical Political Action Committee, came into being about eight years ago. In eight years it has achieved an enviable position as the major spokesman for sound constitutional government for both political parties. AMPAC and COMPAC, the Colorado Medical Political Action Committee, have done this by educating, encouraging, and stimulating our members to take a more active and effective part in governmental affairs. When our members have come to understand the nature and action of government, they have been more successful in carrying out their formerly neglected civic responsibilities.

COMPAC is a voluntary, non-profit, unincorporated committee endorsed by the constituent societies that represent the physicians, dentists, and veterinarians in the State of Colorado. We are not affiliated with any political party, but we certainly encourage our members to participate actively in the party of their choice.

Our final goal is to make every member of our constituent societies feel the need for achieving individual political responsibility. Medical political responsibility is the only way that medicine will be able to guide and to provide for the medical needs of the future. We have successfully demonstrated that medicine can elect conscientious candidates for office, and through continued UNITED political action our efforts will develop and achieve goals thought now to be impossible.

Join your state PAC now!

Isn't that a great piece? When I first saw it I thought it demonstrated a tremendous insight. Dr. Candlin captured the essence of what was **beginning** to happen to medical practice 27 years ago, and it is still happening.

I would be so bold as to say that the elements which have held our profession together are: Legislative efforts by organized medicine; Medical political action committees; Coalition of health care professionals, and; the devotion of physicians like you to the protection of the patient and continuation of the world's greatest profession in the world's greatest health care delivery system. If you haven't already done so, please send your COMPAC dues check today. For questions, call Lorraine Koehn or Suzanne Hamilton in the CMS Government Relations office.

I nformed Consent

From The Other Side of The Desk

by **Jerome Buckley, M.D.**
Chairman & CEO
Copic Insurance Company



"I am now on the way to recovery, having benefited from the finest medical technology in the world, in the hands of superbly trained surgeons who took their time to properly inform this patient and get his consent."

Informed consent is defined as the verbal discussion with a patient about the benefits and risks of a procedure. The **consent form** is the documentation, signed by the patient and physician, which substantiates that informed consent has taken place. Having recently had eye surgery for a detached retina, removal of the vitreous and an injection of an air/gas mixture, I had an opportunity as a patient to be on the other side of the desk for this process.

First, my ophthalmological surgeon himself discussed with me the necessary **procedure(s)** and their **indication(s)**. As they were discussed, he filled in the Informed Consent documentation form with my name and his name, as well as the anticipated procedures and the reasons why the procedures were necessary. Already listed on the printed form were eight **common risks** associated with the procedures. These were individually discussed and then the most **significant risks** associated with the procedures were hand-written in as they were discussed. They included the potential for more retinal detachment, progression of my cataract, increased pressure in the eye infection and bleeding.

The **alternatives** available to me were likewise discussed, including the option to do nothing. The potential need for **additional procedures** was outlined should intra-operative problems occur. The **risks of anesthesia**, including death, and the **lack of a guarantee** were also specifically mentioned. I was

allowed time to **ask questions** and then was asked to **reread the form** that we (my ophthalmologist and I), in essence, filled in together. My wife was also asked to be present and was asked if she had questions. She signed the consent form as a witness and I signed as the patient. Although I am a physician, all of the discussion was in **lay terms** that my wife could understand. Before I signed, I looked at the form and especially noted the significant risks, the potential for death and the lack of a guarantee. It's not fun being on this side of the desk.

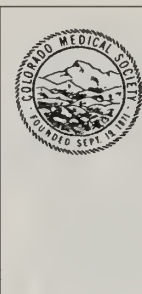
Much to my disappointment and even more so to my surgeon, one of the significant risks did occur -- that of secondary increased pressure. However, my wife and I clearly knew it was a possibility and we accepted that risk for the anticipated benefits. Thank God the secondary glaucoma was superbly managed by my surgeon and the other specialists he called to assist. I am now on the way to recovery, having benefited from the finest medical technology in the world, in the hands of superbly trained surgeons who took their time to properly inform this patient and get his consent.

I prefer to be on the other side of the desk. I must add my compliments to all of you who, on a daily basis, provide and document **Informed Consent** in an exemplary fashion.

NOTE: **Bold type** items point out critical elements of proper informed consent.

MEDICAL OFFICE AUTOMATION

*The computer's place in today's medical practice:
some helpful tips, experiences and guidelines for physicians*



Peter W. Peterson, M.D.*, Denver, Colorado
CMS Office Automation Subcommittee

Sitting in the intensive care unit one evening I was faced with a patient on a ventilator with a rising potassium, approaching 6.0, and I was wondering what was causing it. She didn't have any potassium in her IVs and there didn't seem to be any medications that I could identify that cause this. She wasn't acidotic. I didn't think she had Addison's disease.

I pulled out my **Franklin**[®], my palmtop computer system, which has inserts available for different books. I have the *Physician's Desk Reference (PDR)*, and an abbreviated version of *Harrison's Textbook of Medicine* as inserts for the computer. I decided to look it up in Harrison's. Typing in hyperkalemia, and then choosing the appropriate function keys, I was able to skip to all the places in the text where "hyperkalemia" appeared. In the course of doing that I came across "hypo-reninemic hypoaldosteronism". Following up on that lead, I was able to look at the causes of this syndrome. She was diabetic, and that is one of the causes listed in the text, but the one I was surprised to find, was heparin as a cause of this syndrome. She was also on heparin.

After drawing a renin level and an aldosterone level, she was started on Florinef. This succeeded in bringing her potassium into a normal range. The renin level was within normal range, but the aldosterone was undetectable.

Another patient presented a problem in the office. He had bizarre neurologic signs and symptoms.

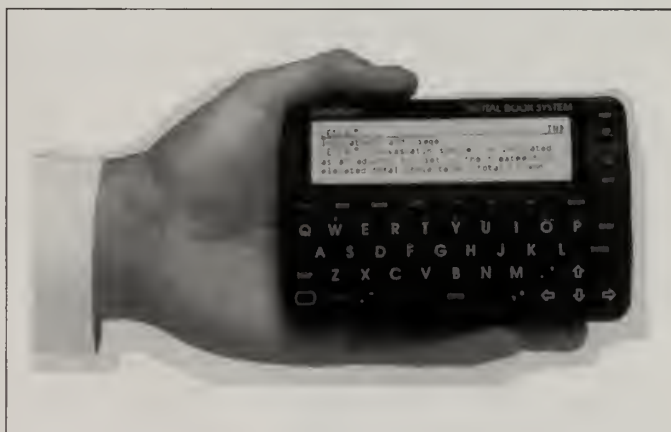
I thought maybe he had some type of vasculitis. By typing in "vasculitis", I was able to come up with a diagnosis of "isolated cerebral vasculitis". Guess what: his cerebral angiogram was positive! This allowed me to direct him to someone who knows about this diagnosis, and who has seen more than just my patient, which was my total experience with this disorder.

COMMENT:

The **Franklin**[®] is a very useful palmtop computer. I use the *PDR* so frequently it's almost on a daily basis. *Harrison's* I use less, but it is still a very useful text to carry around, as in the example above. The other useful insert is the *Medical Letter Handbook of Drug Interactions*.

The **Franklin**[®] has helped me decide about some of the interactions of the medications my patients are receiving. The one problem I have had with the Franklin is that the action of the system program (not the inserts) has gone on the fritz at times, and I have had to send it back for repairs.

Using the Franklin System[®] in practice



The Franklin System[®] a palmtop computer and operating system

* Ed. Note: Dr. Peterson is an Internist specializing in pulmonary diseases and practices in Denver.

The CME Challenge:

Are Physicians Learning Anything?

Lorraine K. Heth, Program Manager
Colorado Medical Society

This two-part article is written with the objective of reminding physicians that a personal commitment to lifelong learning is a key factor in maintaining high-quality patient care.

Are you choosing CME activities based on *real, identifiable* learning needs? Are you tuned into your learning style — Are you auditory, visual or kinesthetic? Are you asking CME staffers and Committee members to provide you with activities pertinent to your needs *and* learning style?

The March, 1993 edition of the New York State Journal of Medicine contains a commentary, "Personal and Self-Directed Continuing Medical Education," admonishing accredited CME providers for continuing to place heavy emphasis on the standard lecture in the majority of CME offered to physicians. The author, Charles D. Sherman, Jr., MD, summarizes by saying, "...the key elements in our CME enterprise in the 90s should be the following: personal, self-directed, interactive, individualized learning with the providers becoming facilitators of the process..." Indeed, it is widely accepted that adult learners retain information longer when education is interactive and/or individualized. In an effort to meet this challenge, what follows is information on how physicians can *actively participate* in changing the learning process.

Medical Library

In a study by Dr. Joanne Marshall of 15 hospitals in the Rochester, NY area with 208 physicians participating, the following was learned: 97% reported that information from their medical library contributed to better informed clinical decisions; 51% said computerized search information influenced their choice of test, 45% their choice of drug, 29% said it changed or confirmed their diagnosis; 19% stated that library information contributed to their ability to avoid patient mortality!¹ Use of the medical library continues to be vital in educating physicians *when it is needed*. Physicians should be actively involved in library resource development — personal and institutional. Access to information electronically is not the wave of the future, it is in the present — are you on the highway or off the track?

Individualized Learning

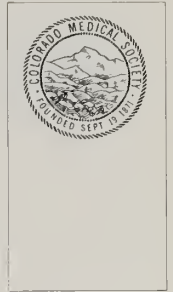
Developing a one or two-year educational plan including wants, needs and goals can be useful to many physicians.² This is not necessarily education in isolation, but an individualized plan incorporating independent work with formal CME offerings. The difference is that the physician has a plan of action for educating him or her self according to his/her individual practice thereby focusing choices on those activities that will truly benefit patient care.

Some physicians have resources available within their organization to facilitate and assist with this activity (i.e., CME staff); those who do not may receive assistance from Colorado Personalized Education for Physicians (CPEP). CPEP is especially helpful with assessment techniques to assist with identification of an individual's educational needs and learning style. Other types of individualized learning include designing education for small groups. This is particularly important to specialists practicing in geographically isolated areas where CME is typically aimed at the primary care physician. Facilitating these activities may begin with Journal Clubs or case discussion groups. Again, CPEP may be helpful in designing activities if your CME department is unable to do so.

¹Bedard, M. WM Winter '93: "Hospital Libraries Are Your Gateway to Better Patient Care," pp 23-26.

²Cervero, RM, Azzaretto, JF & Assoc (1990). *Visions for the Future of Cont Prof Educ*. Georgia Center for Continuing Education, The Univ. of Ga.

Next Month: Formal Educational Programs



PROCEEDINGS OF THE HOUSE OF DELEGATES ANNUAL MEETING 1995

The Colorado Medical Society House of Delegates met at the Ritz Carlton Hotel, Aspen, Colorado, September 8 - 10, 1995, and took the following actions:

REFERENCE COMMITTEE ON BOARD OF DIRECTORS/ CONSTITUTION & BYLAWS

Adopted a Resolution which commends the University of Colorado School of Medicine for its incorporation of primary care into the core of the medical school curriculum.

Adopted a Resolution that our Colorado Medical Society oppose elimination of the in-school interest exemption for federal student loans.

Adopted a Resolution which commends the University of Colorado School of Medicine for its incorporation of a medical ethics course into its core curriculum and the Student Committee on Ethics for promoting awareness among students of ethics issues.

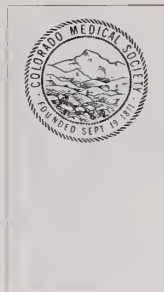
Adopted a Resolution which calls for the formation of a Task Force to explore methods to increase the involvement of University faculty and other institutionally based physician groups.

Referred to the Council on Ethical and Judicial Affairs for additional study, a Resolution which called for the adoption of the American Medical Association Guidelines on Physician Participation in Executions.

Referred to the Board of Directors for additional study, a Resolution which called for the development of a Stress Management seminar for member physicians.

Accepted for filing:

- Progress Report - AMA Delegation
- Progress Report - Board of Directors
- Progress Report - Executive Director
- Progress Report - CMS Education & Research Foundation
- Progress Report - Organizational Study Committee
- Progress Report - Reorganization Task Force
- Progress Report - Women in Medicine



125TH ANNUAL MEETING

REFERENCE COMMITTEE ON HEALTH AFFAIRS

- Adopted** a Resolution which states that CMS will encourage and endorse broad-based, cross-specialty training and retraining for primary care physicians wishing to practice in rural areas.
- Adopted** three Resolutions that sunset several environment related policies which were outdated and amended others to reflect sound policy regarding the Rocky Flats facility.
- Adopted** a Resolution that the Colorado Medical Society work with Colorado professional liability insurers and other interested parties to investigate and recommend ways to extend professional review authority to other organizations of physicians.
- Adopted** a Resolution that the Colorado Medical Society appoint a collaborative task force to work with appropriate representatives of the Colorado State Board of Medical Examiners regarding the issue of practice monitoring.
- Adopted** a Resolution which calls for the elimination or reduction of the medical license fee for those retired physicians who volunteer services to the indigent community.
- Adopted** a Resolution that the Colorado Medical Society support voluntary HIV testing for all pregnant women as a part of the routine prenatal screening tests.
- Adopted** a Resolution that the Colorado Medical Society recommend and encourage the use of appropriate safety equipment by in-line skaters as well as in a wide range of activities with particular emphasis on multiple-use helmets.
- Adopted** a Resolution that the Colorado Medical Society opposes the use of the Medicare Fee Schedule by payers other than Medicare.
- Referred** to the Board of Directors for review, a Resolution which called for the Colorado Medical Society to form a clearinghouse for review of managed care contracts.
- Referred** to the Health Affairs Council for additional study, a Resolution that the Colorado Medical Society recommend a program of gun safety to all Colorado school districts.
- Referred** to the Board of Directors for review, a Resolution which called for the development of a program of communication to the grassroots members regarding policy decisions and legislative matters.
- Referred** to the Health Affairs Council for review, a Resolution that the Colorado Medical Society study the most appropriate methods of disseminating information regarding public access to physician information.
- Referred** to the Health Affairs Council for study, a Resolution regarding the length of hospital stay following obstetric delivery.

Accepted for filing:

Progress Report - Health Affairs Council
Progress Report - Council on Legislation
Progress Report - COMPAC

125TH ANNUAL MEETING



AFFILIATION

Registrant

(ACEP) COLO. CHAPTER

Murphy, Carla

ARAPAHOE

Aarestad, Norman

Alvarez, Raul

Bartee, Roy

Bartlett, Max

Capek, Richard

Carlson, Roy

DeLine, James

Foss, Frederick

Hoehn, Robert

Jolly, Susan

Kortz, Allan

Krauth, Lee

Kreye, George

Lazarus, Jeremy

Lennon, Kelly

Levine, Mark

Lewis, Frederick

Ratner, Karen

Sabel, John

Schreiber, David

Stecher, Karl

Stienmier, Richard

Truitt, Leigh

Whalen, William

Winter, Clara

AURORA-ADAMS COUNTY

Gottula, Roderic

Greos, Leon

Heaton, Angeline

Heaton, Carl

Manguso, Robert

O'Dell, Robert

Press, Peter

Rich, John

Sherman, Eugene

Spaulding, Harry

Sundland, Barry

Unrein, Christopher

Visconti, Paul

Vitanza, Joanne

BOULDER COUNTY

Benson, Alan

Bolles, Gene

Carr, Alfred

Mooney, Herbert

Stjernholm, Melvin

VanHook, Charles

Wherry, Harry

Williams, William

CLEAR CREEK VALLEY

Brundige, Richard

Cedars, Chester

Cohen, Richard

Daneshbod-Skibba, Ghodsi

Day, James

Doig, William

Dougall, Dorin

Glismann, John

Golbert, Thomas

Kief, Jan

Mains, Charles

Mozia, Nelson

Netz, Howard

Oppenheim, Walter

Parry, Lynn

Sadler, Dean

Siegel, Gary

Tegtmeier, Ronald

Volz, Michael

Yocum, Harold

CO GYN/OB SOCIETY

Jacobs, Herbert

CO SOC OF CLINICAL PATHOLOGISTS

Merrick, Thomas

CO SOC OF INTERNAL MEDICINE

Abbey, David

CO SOC OF PLASTIC/RECON SURG

Zwiebel, Paul

CURECANTI

Canfield, Thomas

Hopple, Lynwood

DENVER

Allen, Richard

Bakemeier, Richard

Anneberg, Lee

Bogin, Robert

Broughton, Joseph

Butterfield, D. G.

Campbell, David

Campbell, William

Carson, Bonita

Douthit, John

Foust, Glenn

Hedberg, John

Hutchison, David

Jacobs, Mary Jo

Jacobson, Eugene

Kandel, George

Kelble, David

Levine, Joel

Lightburn, John

Manart, Frank

McCallum, Douglas

McCartney, Robert

Nelson, Nancy

Nichols, John

Reed, Barbara

Regan, James

Rhodes, Edward

Sawyer, Robert

Schemmel, Janet

Schoonmaker, Fred

Starr, Arthur

Steffen, Grant

Walker, Louise

Wiedel, Jerome

Winter, William

EASTERN COLORADO

Fox, John

EL PASO COUNTY

Cole, Norman

Collister, Richard

Crawford, Lewis

Emeis, William

Feinsod, Fred

Fitzgerald, Edward

Genrich, John

Goldmuntz, Barry

Greenberg, David

Lloyd, William



125TH ANNUAL MEETING

Moore, Larry
Nielsen, Peter
Pero, Robert
Rapp, Alan
Reimers, Bruce
Rubinow, Sidney
Sherman, John
Simerville, James
Spaulding, Duane
Struck, Teresa
Wall, Paul

FREMONT COUNTY

Buglewicz, John
Gamache, Peter

GYN/OB SOCIETY

Ganter, Debra

INTERMOUNTAIN

Feeney, Jonathan

LARIMER COUNTY

Belleville, Bruce
Carroll, Cory
Eriksen, Christopher
Ezell, William
Honea, Bertrand
Nemeth, Clifford
Rule, Ingrid
Tagge, Gordon

LAS ANIMAS COUNTY

McFarland, Douglas

MEDICAL STUDENT COMPONENT

Abbey, Nick
Abbey, Shauna
Eisenach, John
Fegley, Phaedra
Fetterman, Hilary

MESA COUNTY

Doran, John
Golter, Lee
Jones, Paul
Magraw, Bronwen
Moore, Richard
Sadler, Theodore
Walker, Frederic
Webel, Jacob

MORGAN COUNTY

Thompson, Patrick

MT. SOPRIS COUNTY

Painter, Ray
Rodriguez, José

NORTHEAST COLORADO

Bonelli, Joseph

NORTHWESTERN COLORADO

Scanlon, Charlotte

OTERO COUNTY

Satt, James

PUEBLO COUNTY

Chimento, James
Drake, Robert
Morgan, Alethia

Parks, Gary
Parks, Pamela
Ryals, Jarvis
Snyder, Charles
Tonsing, Robert
Wilz, William

WASHINGTON-YUMA COUNTY

Kitagawa, Benji

WELD COUNTY

Flower, Thomas
Groves, Robert
Quinn, Richert
Vaughan, Judith

WOMEN IN MEDICINE SECTION

VanScoy, Sarah

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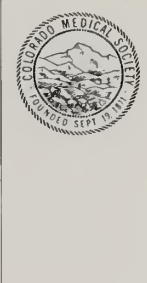


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Dear Friends:

As many of you know, I was not successful in my bid for the presidency of Colorado Medical Society. I want to extend my congratulations and best wishes for success to Dr. M. Ray Painter, who was elected during the recent CMS meeting in Aspen.

The time and effort involved in the campaign were worthwhile in several ways. Perhaps the most important is that I was provided an opportunity — that I might otherwise not have had — to meet and speak with so many of you. Our encouragement and your support meant a great deal to me, and I want to express my very real appreciation.

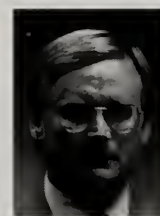
These are difficult times for the medical profession. It is important

that we all work together to maintain standards of practice, to ensure the protection of our best interests and, most important, the best interests of our patients. While there may be many ways to address a problem, while there may not always be agreement on the best solution, it is vital that we all work together and, whenever possible, present a unified front in combating those who would attempt to control or demean the practice of medicine.

Again, many thanks for your support and for your continued loyalty to the Colorado Medical Society.

Sincerely,

Terry Sullivan, MD



*many thanks
for your
support*

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - September 7, 1995

- Copic:** Myron Treber, Vice President, Management Services presented a Seminar entitled "Know Your Boundaries".
- CMSA:** Ms. Patti Brown, President expressed her gratitude to the Board of Directors for their support of the Alliance efforts to promote the nationwide effort to "SAVE - Stop America's Violence Everywhere".
- Board of Directors:** The Board approved a membership marketing plan which offers a 3 month free membership to the "local membership only" classification of physicians. The Board approved the development of a questionnaire for distribution to the House of Delegates asking for input as to what kinds of education and training would be most beneficial to the members if the Colorado Medical Society were to create an educational function.



Patti Brown, President
Colorado Medical Society Alliance



SAVE Today *Stop America's Violence Everywhere*

SAVE or Stop America's Violence Everywhere is a program launched by the AMA Alliance and is intended to be year round program to emphasize violence prevention in communities nationwide. The first annual SAVE Day is October 11, 1995.

The Colorado Alliance, with the help of Ceis Sexton Photographic Imaging, has designed and produced 500 "Don't Suffer in Silence" posters. These posters detail what is abuse, and include a pad with tear-off sheets of crisis numbers for victims of domestic abuse. We would like these distributed statewide and in every hospital ER, women's clinic, schools, etc. If you can help by hanging one up — call Patti Brown (303) 988-0888 or Sonnie Talley (303) 795-5719 and we will get them to you.

Other ways you can be involved include:

- writing an editorial for your newspaper to raise awareness about the problem of violence.
- contact your child's school and encourage activities that teach conflict resolution, guest speakers to highlight violence and its effects, signing pledges against violence, turn off the TV for one day, discuss gratuitous violence, a community service project to help a local women's shelter.
- cut out an article on violence

and write about it.

- contact media with comments about programming, and/or articles that seem to highlight violence inappropriately.
- purchase the AMA Alliance's "I Can Choose" workbook for K-3 children that teaches conflict resolution. (100 for \$34.95 — contact Patti Brown). These make great gifts to honor your child's birthday for their school.

Plan to join the Metro Denver Alliance at 7 pm on October 11, 1995 at the Denver City and County Building for a candlelight vigil. We need as many people as possible to attend the vigil to convey our message to Stop America's Violence Everywhere. Grand Junction is also planning a vigil on that day as well and needs your support.

Please help us with these grassroots solutions to the problem of violence in our community. Each journey of a thousand miles begins with a single step — each effort, no matter how small, will help us become part of the solution, not part of the problem.

Thanks to these physicians for already agreeing to distribute the posters and the *I Can Choose* Workbooks: Nancy Nelson, MD, John Genrich, MD, Ingrid Rule, MD, Duane Spaulding, MD, Roderic Gottula, MD, Thomas Flower, DO, Jack Berry, MD, Paul Wall, MD, Angela Heaton, MD, Louise Walker, MD, W. Carl Bailey, MD.



Colorado Department of
Public Health and
Environment



Hepatitis A Vaccine Recommended for International Travelers

Due to the nationwide shortage of immune globulin, the Colorado Department of Public Health and Environment is recommending that Coloradans traveling outside of the country receive the hepatitis A vaccine, instead of immune globulin, at least two weeks and preferably four weeks before departure.

Most travelers to developing countries have long been aware of the need to be protected against hepatitis A infection, a highly contagious virus spread by eating or drinking contaminated food or water or by poor hygiene. A common preventive practice for frequent travelers has been to obtain injections of immune globulin. However, because of the short supply, immune globulin is being used primarily for those who have already been exposed to the virus. As a result, the department is recommending use of the hepatitis A vaccine.

Pam Shillam, a department epidemiologist, said, "Fortunately, there is an alternative to immune globulin. The hepatitis A vaccine offers additional benefits. The vaccine provides longer lasting protection — possibly 20 years or longer when adults receive a two-dose series and children a three dose series. Immune globulin currently only provides a three-month window of protection against the disease."

With 400-900 cases of Hepatitis A reported in Colorado each year, the Hepatitis A vaccine also offers protection against the infection

when exposed in Colorado.

Shillam pointed out that the hepatitis A vaccine recently was approved for use in the United States and is available through most private physicians and travel clinics.

For more information regarding hepatitis A and the vaccine now available, call (303) 692-2700, or your county health department.

CDPHE recommends hepatitis A vaccine instead of immune globulin for international travelers.

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Vendors may be causing Medicaid rejections

K. Suzanne Hamilton, Program Manager
Colorado Medical Society

Colorado physicians face 26% rejection rate with Automated Medical Payment system

The Colorado Medical Society (CMS) continues to work in collaboration with the Department of Health Care Policy & Financing (Medicaid) to assist physicians in billing the Medicaid program. CMS and Medicaid have been looking into the high number of rejected claims (26%) that the physician community is experiencing through the Automated Medical Payments (AMPs) system.

The top five rejection reasons identified are as follows: 1) Timely filing - in researching this error the Department has found that a number of physicians using vendors or billing services have not been receiving their rejection reports and do not discover claims have been rejected until they are out of timely filing; 2) Invalid or missing Primary Care Physician (PCP) number - this error on AMP is a result of vendor mapping problems, billing services misunderstanding of the uses of rendering physician versus referring PCP and physicians not checking eligibility before submitting the claim; 3) Bill Medicare first - due in part to vendors not identifying Medicare claims appropriately so that they are being routed to Medicaid first and additionally not completing the Medicare coinsurance, deductible and explanation of benefits information to allow the secondary billing to Medicaid to be processed electronically; 4) Providers are attempting to bill Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) screenings without using the appropriate EPSDT screening format - again, this is primarily a vendor/billing service

education and development issue; and 5) Recipient not eligible on dates of services - this is primarily a result of not checking eligibility before submitting the claim.

Since four of the top five reasons for rejection result from vendor problems, CMS and Medicaid are taking steps to assist the physician community in selecting a vendor. Below, we have identified some questions your office may want to ask a vendor prior to contracting with them, or you may use the following questions to evaluate the level of service you are getting from your current vendor.

Question to ask Vendors

1. Is the vendor/billing service an approved Colorado Medicaid Electronic Media Claims (EMC) submitter and, if applicable, is the vendor/billing service approved to send Medicaid EPSDT claims and medical supply claims?
2. Does the software capture and transmit Colorado Medicaid specific information including the new AMP information—
 - Colorado Medicaid late bill override date,
 - Third party payment information,
 - Medicare crossover information,
 - Colorado Medicaid specific modifiers,
 - Colorado Medicaid primary care physician referral information.
3. Is there a per claim charge for claim submission? Are claims transmitted directly to the Blue Cross Blue Shield electronic

REJECTED

bulletin board (EMSNET) or are they sent through a clearinghouse? If a clearinghouse is used, what is the "per claim" charge for the clearinghouse?

4. When are batch claims actually submitted? At will, on a time schedule, at night, daily, weekly, etc. NOTE: If the vendor holds claims and transmits only at a specific time, timely filing requirements may be missed.
5. How are Medicaid AMP acceptance/rejection reports retrieved? Are the reports available the same day? Can the vendor/billing service access reports? Can the physician access reports?
 - NOTE: If AMP batch acceptance/rejection reports are not retrieved and reviewed the same day, the physician does not benefit from interactive processing. If the vendor/billing service retrieves and reformats the AMP batch report, the report may not be acceptable as proof of timely filing if it does not contain all of the information on the AMP reports including the AMP transmission date.
6. Does the vendor provide free software modifications/updates if needed to comply with insurance billing requirements (HCFA, Medicare, Medicaid, other insurance company changes)? Is additional training made available at no cost when modifications/updates are made?
7. Is the company well established? Is it a national company?
8. Is support local? Is there a toll free telephone number? What are the hours? Is there a beeper system to provider immediate

responses?

9. Is the equipment proprietary or is it a standard brand so that you could add your own additional printers, PC's, etc.? Is the equipment IBM compatible?
10. Is the system DOS, Unix, or proprietary?
 - NOTE: Medicaid AMP interactive software is only available for DOS operating systems. Blue Cross Blue Shield of Colorado provides full support to DOS applications. Only DOS and Unix systems can access EMSNET, Blue Cross Blue Shield's electronic bulletin board system. Proprietary systems may not be able to run AMP software and may not be able to access EMSNET to retrieve AMP reports.
11. Does the software have batch billing capability and interactive billing capability?
 - NOTE: Interactive capability is nice to have for submitting claims that have been rejected from the batch billing process and essential for appeals.
12. Does the software have Medicaid interactive eligibility verification capability?
13. What kind of editing does the software provide? Validity edits: dates, provider numbers, recipient ID number, Required information editing: missing or blank fields. How are changes to the edit criteria made? Who makes the changes to the editing criteria? How long does it take? Are there charges for making criteria changes?
14. Can electronic submission be suppressed? Of any claim? Of a group of claims? Can a claim or

Four of the top five reasons for rejection result from vendor problems.

REJECTED

Question to ask vendors of Medicaid billing systems

- group of claims be diverted to paper instead of electronic billing?
- NOTE: Medicaid requires that some claims be submitted on paper. If claims that must be filed on paper are filed electronically, the provider receives a claim rejection and still pays an AMP transaction fee.
15. Is there a local user group for ongoing education? Is there a newsletter?
 16. Ask to see the user's documentation, and depending upon the office staff's level of computer expertise, the software documentation. Is it readable and understandable?
 17. How many hours of training will you receive? Is the training over the telephone or in person? At your office or the vendor's facility? Do they offer free follow-up training if office personnel or billing requirements change? If not free, what are the charges?
 18. Can the vendor dial into your system for remote diagnosis of problems and to download updates?
 19. If a billing service is used, what reports are available to assist in managing your practice? Do they serve as a collection agency too?
 - NOTE: Get a full understanding of reports from the service that allow you to monitor the results of the billing effort. You need to have ways to review reimbursement levels (by payer), claim acceptance/rejection/denial rates (by payer), and account aging statistics individually and by payer.
20. Is the hardware compatible with Medicaid interactive processing software? Will you need to buy a separate system for eligibility?
 21. Who supports the equipment? Do they come to the office? Are there additional charges for equipment maintenance and troubleshooting calls?
 22. What is the cost if you need to buy another terminal or PC as your practice grows and what will the software license cost to add users?
 23. If you have an equipment failure, will you get a loaner to use? Is there a cost for the loaner?
 24. Does the vendor/billing service subscribe to Medicaid publications?
 - NOTE: Vendors may call Medicaid Communications to request information on subscriptions to Medicaid publications. Practitioner Operations—303 831-0504 Metro Denver, 800 443-5747 Toll Free Colorado.
 25. How often are new versions of the software released and what is the charge to purchase the new version?
 26. Do not call a vendor/billing service's "testimonial list". Instead, do your own independent research by talking to other offices' staff. The staff can tell you how quickly support calls are returned and what service is like - after the sale has been made.
If you need further information or have questions regarding Medicaid, please contact Suzanne Hamilton at (303)779-5455 or (800)654-5653 or Beth Neva at Blue Cross Blue Shield of Colorado.

9Health Fair

Endorsed by the Colorado Medical Society

Again this year, the Colorado Medical Society continues its endorsement of the 9Health Fair, the only health fair endorsed by the Society. The 9Health Fair will be held April 13-21, 1996.

In its 17th year, 9Health Fair continues to offer health education and physical screening to persons over 18 years of age throughout Colorado. Last year, 37,608 persons attended these screenings at 116 sites. There are two levels, basic and supplemental screening, offered. Basic screening consists of 1) registration, 2) height & weight, 3) Blood pressure, 4) Blood chemistry, 5) Vision, 6) Summary & referral, and 7) Colorectal cancer. The supplemental screening includes hearing, oral cancer, foot, breast exam, skin fold, pap smear, peripheral vascular disease, glaucoma, prostate cancer, skin cancer, testicular cancer, body in balance, and lung function. In 1995, 32,698 opted for a blood chemistry test. Physicians volunteer at statewide public fairs. You can call CMS at 800-654-5653, Ext. 2418 for information, or 9Health Fair at (303) 698-4455.

Sponsors of the 9Health Fair include Provenant Health Partners (Provenant St. Anthony Hospitals Central and North, and Provenant Mercy Medical Center), Tri-State Banks, Lions Clubs of Colorado, the Colorado National Guard, Metra-Health and 9News/KUSA.

9Health Fair maintains a Medical Advisory Committee made up of physicians and other health care professionals. Members are:

Robert B. Sawyer, MD
Eugene Weston, MD
Sherry Laubach, MD
Elizabeth Ritchey, MD
Robert Bogin, MD
Debra Ginsburg, RN
Kristine Gonzalez, RN
Judy Bailey and
Marge Bell-Kohler
Corning Clinical Laboratories.

COLORADO MEDICAL SOCIETY 1995 STUDENT LEADERSHIP AWARD



Nick Slenkovich

In the nomination for this award, Nick was described as an influential student leader, an innovative organizer and executor, and an inspiration to the newer medical students.

During the past two years, Nick Slenkovich has been most active in the recruitment of members to the Medical Student Component Society (MSC), seeing that organization grow by 105 new members. He has served two terms as President of MSC and, as such, has represented the students to the CMS Board of Directors.

One of the most outstanding aspects of Nick's leadership ability has been the developing and shaping of new leaders among the medical student body. Colorado Medical Society has seen a marked increase in both the effective representation and participation of the students. This has been achieved, to a great extent, through Nick's work with the first and second year students, bringing them into the

The recipient of the Colorado Medical Society 1995 Student Leadership Award is Nick Slenkovich.

organized medicine loop, networking their concerns and producing effective representation at the CMS Board and Reference Committee levels.

Another outstanding accomplishment of Nick Slenkovich's leadership has been the creation of an effective and polished student component society newsletter. This has been, according to Nick, a highly effective tool in his membership development campaign for two years. Nick has shown himself to be an excellent communicator, and this talent alone has earned him plaudits from all levels of Colorado Medical Society membership.

Nick Slenkovich has also been a major player in presentations during student orientation sessions. These sessions have been highly successful in presenting the Colorado Medical Society to the students on a clear and meaningful plane.

The nominating statement closed by saying: "In short, Nick has demonstrated outstanding leadership, and in doing so, has brought considerable new success to the Medical Student Component and its members".

The award carries with it a \$500 stipend and a certificate from CMS recognizing the recipient's outstanding accomplishments.



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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

Life used to be so simple. . .

before all of the time- and effort-saving devices came along. When I was a reporter and I was assigned to cover a story: it was a matter of going to the person or event, getting the facts (or as near to the facts as I could get), then returning to the newsroom and writing the story. If I wanted to talk to someone not in my presence, I either called them on the phone, talked directly to them, or I wrote them a letter and usually got a direct reply from that person. Any more, I don't expect to talk to the intended "callee", but instead to some computerized "echoscape". There's going to be a day of reckoning for all this effort-saving.

In the early days of TV, when we received a picture from Associated Press or other wire service by facsimile, the picture was transmitted, line-by-line, slowly, surely. An 8 X 10 photo usually took 3 to 4 minutes to transmit.

Of course, along about the same time as those original facsimile machines (circa late-'40s) came the two-way radio for business use. Both were outgrowths of World War II. I had a 2-way in my car (it took up most of the trunk of a 4-dr sedan). I could talk to my office and they could find me. With this came the radio-telephone, which was no more than the 2-way radio with a dial-up capability. In other words, radio to hard-wired telephone, or vice-versa. The fact that it was transmitting through the air made it possible for others to tune the frequency and listen to your conversation. This, by the way, was not illegal. . . just improper.

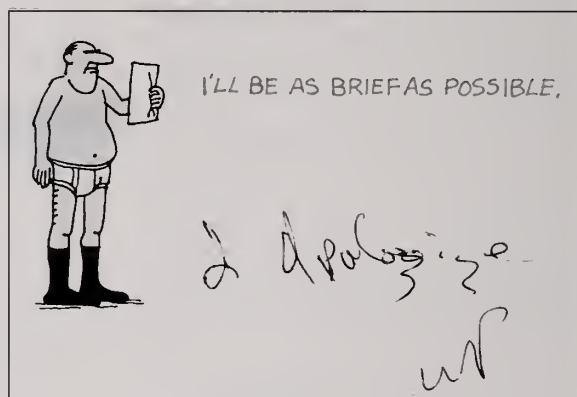
I remember doing this once on a Sunday morning on my way to the station, and I heard a man's voice I recognized talking to someone who was very obviously not his wife. It was a rather embarrassing conversation for me. The instigator of this call died before I ever had a chance to tell him I was listening when he talked to "Babe". There were other memorable calls, like the guy who called his wife (at about 5:20 pm) and said "Honey, I have to work this evening, so don't keep dinner. I don't know when I'll be home. Don't wait up. Love you! Bye". Immediately after, the same guy called this **other** woman and said "Everything's set. I'll pick you up in 30 minutes".

My wife caught me on the 2-way once when she was driving my car. However, I was in the Denver Zoo using my "walkie-tralkie" talking to a male lion. Did she think I was weird! That was the last time my wife listened in.

Last night, a person FAXed me some art work — I don't know when — it was as if the "FAX" had sneaked into my house and, had it been a malicious "FAX", could have done all sorts of damage. Instead, it came in without a sound, found a spot on my computer, imbedded itself in a file the computer created for it when it arrived, and there it lay awaiting my assessment this morning. I had no idea what had been happening while I slept soundly. . . **in the same house!** This is getting dangerously close to invasion of

privacy.

Just last year I had an innocent yet very embarrassing incident occur when I had to cancel a luncheon meeting with a business associate from California. She had flown to Denver for several meetings, and I was the lucky one chosen for luncheon, but I had to cancel. To lighten up the situation some (I



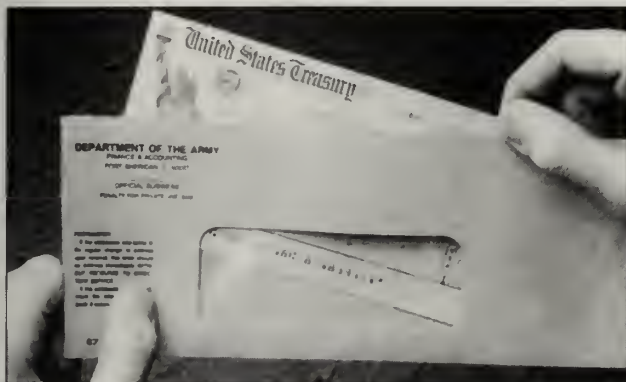
thought), I FAXed her the note below: Can you imagine how I felt when her corporate boss called up (from back east) and said "Mr. Pierson, I don't understand the note you FAXed the other day. The one with the man standing there in his underwear. Could you explain it?" It was very difficult to do! I deserved to sweat.

I had sent the message to the corporate office instead of my business friend's personal FAX in California.

What I'm leading up to is the question of "Should we sell our souls to the modern-day convenience so easily, even to the extent of "FAXing" patient's medical records? I think not! This bears serious consideration. More later.

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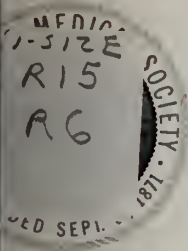
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COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

November, 1995

Volume 92, Number 11

We are entering a political season the likes of which have never been seen for its number and severity of assaults on medicine and health care.

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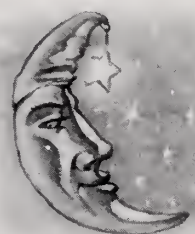


This Issue:

- The Data Commission is Dead: Long Live Data Gathering** *Joel M. Karlin, MD*
It's a trumpet on a board, but it means a lot **Page 378**
Physicians and Continuing Medical Education—Part Two **Page 386**
Docs turn out for Medical Informatics Fair **Page 390**

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a malpractice suit
could turn your
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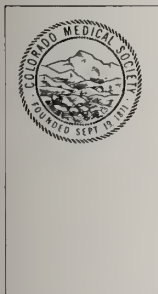
November, 1995

Volume 92, Number 11



Cover Story

COMPAC has been around for a number of years, but it is more important now than ever. If you're a member, thanks! If not, join today! Your patients will thank you for years to come.



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The Sharing the Care program donates Pfizer's full line of single-source pharmaceuticals to medically uninsured, low-income patients of federally qualified centers like Southside, in support of those who, like Dr. Williams, are part of the cure.

Sharing the Care: A Pharmaceuticals Access Program is a joint effort of the National Governors' Association, the National Association of Community Health Centers and Pfizer.



We're part of the cure.

CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax[®]

by **Montgomery Little and McGrew, P.C.**

legal counsel to the Colorado Medical Society

Long-time CMS ally dies

We are sorry to inform you that long-time CMS activist Francis T. Candlin, DVM died October 22 at his Denver home. For those few of you who had not met Dr. Candlin, the description of a DVM as a CMS activist may sound a little odd. For those of us who knew him though, Dr. Candlin was an understated fireball of quiet activism. He didn't make a lot of noise, but he made his presence known in the cause of public health for many years.

Dr. Candlin has been the treasurer and a large part of the driving force behind COMPAC, the Colorado Medical Political Action Committee, for a considerable time. As the only non-physician on this medical PAC,

Dr. Candlin focused his tireless energy on making Colorado a better, healthier place.

In addition to holding "every office in the Colorado and American Veterinary Medical Associations," Dr. Candlin was on the teaching staff of the University of Colorado School of Medicine. He was cited for these and many other accomplishments by the 1966 Annual Session of the CMS House of Delegates, which awarded him the Certificate of Service as a Distinguished Contributor to Public Health.

Look for more information in the December issue of *Colorado Medicine*. Services were scheduled for October 25.

New Changes in Incident Reporting Announced

The Colorado Department of Public Health and Environment, Health Facilities Division, is changing its incident reporting policies and procedures. The changes were recommended by a 23 member task force co-chaired by Acting Executive Director Patti Shwayder and State Representative Mary Ellen Epps. Some were implemented October 1, 1995, while others will require rule changes by the Colorado Board of Health.

The biggest change involves regular preparation and release of summaries of incidents reported to the division on unexplained deaths or serious injuries. The summaries will be released once the division has concluded its investigation or has determined that no further investigation is warranted.

Beginning October 1, 1995, summaries of reported incidents occurring on and after that date are to be prepared by division staff and sent to the facility for review and comment. Facilities will have seven days in which to review the summary and send comments back to the division. Summaries will then be placed in facility files for public viewing.

In order to free up staff time for summary preparation, the division will seek two rule changes from the Board of Health: 1) that the 24-hour reporting requirement for falls which result in fractures, disloca-

tions, concussions or deep lacerations be changed to a written report submitted within seven days of the fall; 2) a proposal to eliminate the six-month statistical reports on less serious incidents. Initially, the division will not prepare summaries of falls. Reports on falls must be written and mailed or faxed to:

Liz Lambrecht, Health Facilities Division
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, Denver, CO. 80222-1530

or faxed to:

Liz Lambrecht at 303-782-4883.

Comments on summaries can be phoned in to: Donna Burgess, Health Facilities Division, at 303-692-2916 or faxed to her at 303-782-4883

By November 1, 1995, consumers will be able to access all public information related to a specific licensed facility by visiting the department's Information Center, located in Denver at 4300 Cherry Creek Drive South, Building A, first floor. Files on each facility, organized by city, will contain ownership information, facility profiles, survey results, deficiency lists, plans of correction, complaint investigation summaries and summaries of reported incidents.

For general questions, call Jackie Starr-Bocian, Public Information Officer, Health Facilities Division, at 303-692-2853.



Med Fax: Medico-Legal News

by David A. Burlage, Esq.,
Shareholder, and Karen B. Best,
Esq., an Associate with the law firm
of Montgomery Little & McGrew, PC.

*This column is not legal advice, but is for general
information only. For help with specific problems,
readers should consult an attorney.*

This is the second of two articles dealing with sexual misconduct as a form of unprofessional misconduct which may subject the physician to sanctions, including suspension and revocation of licensure.

SEXUAL MISCONDUCT BY HEALTHCARE PROFESSIONALS:

THE LICENSING PERSPECTIVE - PART II

Sexual contact between a physician and a patient long has been recognized as an ethical violation of the physician's duty to his or her patients. The professional disciplinary boards, including the Colorado Board of Medical Examiners, oversee the conduct of licensed professionals. The Board's powers include the power to investigate allegations of sexual contact between patient and physician, and the power to summarily suspend licenses pending full hearing.

SEXUAL MISCONDUCT IS A FORM OF UNPROFESSIONAL CONDUCT

The enabling statute for the Board of Medical Examiners defines "Unprofessional Conduct" to include a prohibition against engaging in sexual conduct with a patient. Section 12-36-117 (1)(r), C.R.S. states that the term "unprofessional conduct," as used in this article means engaging in a sexual act with a patient during the course of patient care. Sexual act means sexual contact, sexual intrusion, or sexual penetration as defined in section 18-3-401, C.R.S. Section 12-43-704(1)(q), C.R.S. provides that a person practicing psychotherapy under this article is in violation if he or she has engaged in sexual contact, sexual intrusion, or sexual penetration, as defined in section 18-3-401, C.R.S., with a client during the period of time in which a therapeutic relationship exists, or for up to six months after the period in which such a relationship exists.

DISCIPLINARY SANCTIONS

Most boards, including the Colorado Board of Medical Examiners, have the authority to revoke, suspend or place restrictions on the respondent's professional license, upon a finding of a violation of the Act. 12-36-118(5)(g)(III). The restrictions or sanctions

may include a letter of admonition, private censure, public censure, suspension for a definite or indefinite period, revocation, and probationary status which may include practice and treatment monitoring, continuing education, physical or mental evaluation, therapy, or other restrictions on the physician's practice.

INJUNCTIVE POWER OF THE BOARDS

Most boards also have the ability to seek injunctive relief for statutory violation of their enabling act. For example, the BME "may, in the name of the people of the State of Colorado, through the attorney general of the State of Colorado, apply for an injunction in any court of competent jurisdiction to enjoin any person from committing any act prohibited by the provisions of article 13, 30, 31, 34, 36, or 41 of this title. If it is established that the defendant has been or is committing an act prohibited by said articles, the court shall enter a decree perpetually enjoining said defendant from further committing said act. Such injunctive proceedings shall be in addition to and not in lieu of all penalties and other remedies..."

Additionally, the grievance board may, in the name of the people of the State of Colorado, through the attorney general of the State of Colorado, apply for an injunction in any court of competent jurisdiction: (a) To enjoin any person from committing any act prohibited by the provisions of this article; and (b) If it is established that the defendant has been or is committing any act prohibited by this article, the court shall enter a decree perpetually enjoining said defendant from further committing said act or from practicing psychotherapy; and (c) When seeking an injunction under this section, the grievance board shall not be required to allege or prove either that an adequate remedy at law does not exist or that substantial or irreparable damage would result from a continued violation. § 12-43-708, C.R.S.

PUBLIC DISCLOSURE OF BOARD INVESTIGATION AND ACTION

Any disciplinary action taken by the boards will constitute a public, non-confidential record in the custody of the board. Hearings generally will not be closed to the public absent a compelling reason to protect the complaining party from public dissemination of private information. All pleadings filed in the case will be public documents unless specifically sealed by the Administrative Law Judge. The report of investigation by the Department of Regulatory Agencies, Division of Complaints and Investigations may or may not be open to public inspection depending upon the specific board. Pursuant to Section 12-36-118(10), C.R.S., "Investigation... conducted pursuant to the provisions of the section shall be exempt from the provisions of any law requiring that proceedings of the board be conducted publicly or that the... records of the board... be open to public inspection."

Medico-Legal News (*Continued from page 2*)...

USE OF ADMINISTRATIVE EVIDENCE AND FINDINGS IN CIVIL ACTIONS

The sworn testimony of any deponent or witness testifying at an administrative hearing can probably be used as an admission or for impeachment in a civil proceeding. Answers to requests for admissions propounded by the Board can probably be used as an admission or for impeachment in a civil proceeding. The use of offensive collateral estoppel (claim preclusion) in any civil action requires a showing of five essential elements, all of which must be present: (1) The issue on which preclusion is asserted is identical to the issue actually litigated and necessarily adjudicated in the prior

proceeding; (2) The party against whom preclusion is sought was a party to, or was in privity with, a party to the prior proceeding; (3) There was a final judgment on the merits in the prior proceeding; and (4) The party against whom the doctrine is asserted had a full and fair opportunity to litigate the issue in the prior proceeding. See Public Service of Colorado v. Osmose Wood Preserving, Inc., 813 P. 2d 785, *certiorari denied*. Finally, the evidentiary standard applied to the factual questions in the first proceeding must be equal to or greater than that applicable to the second proceeding.

Next Month: Ethical Considerations and Recommendations

Cardiac Rehab "Under-used"

The Agency for Health Care Policy and Research released guidelines in October which say that cardiac rehabilitation services are widely underutilized, despite their proven benefits. Douglas B. Kamerow, MD, MPH, AHCPR's director of Clinical Practice Guideline Development says that medically supervised interventions aimed at limiting physical and other damage from heart disease that reduce the risk of health and help patients resume a normal life are safe and beneficial when patients have been appropriately screened.

ACPHR is disseminating their clinical practice guidelines on this subject to health professionals and

heart disease patients. They recommend a comprehensive approach that includes exercise training to improve exercise tolerance and stamina, and education, counseling and behavioral interventions to assist patients in achieving and maintaining optimal health. A modified home approach is allowed in certain circumstances.

A quick reference on the guidelines is available free from AHCPR Publications Clearinghouse at 800-358-9295 or through AHCPR InstantFAX at 301-594-2800. The full guideline is available on the Internet at URL <http://text.nlm.nih.gov> or from the US Government Printing Office at 202-512-1800.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Joint Commission on Accreditation of Healthcare Organizations

8th Annual National forum on Health Care Quality
November 8-11, 1995
Chicago, IL
708-916-5800

International Meniere's Disease Research Institute

7th Annual Interdisciplinary Seminar on Diagnostic and Rehabilitative Aspects of Dizziness and Balance Disorders.

December 6-10, 1995, Denver, CO.

Contact: Jane Wells or I. Kaufman Arenberg,
MD.(303)778-4235

American Brachytherapy Society

Annual Mid-Winter meeting

"Brachytherapy: The First Hundred Years"

December 10-13, 1995

Hyatt Regency Scottsdale at Gainey Ranch, Scottsdale, AZ.

Contact: (215) 574-3158

American College of Cardiology

The 27th Annual Cardiovascular Conference at Snowmass(1617)

January 15-19, 1996

Snowmass, Colorado

Contact: 800-257-4739

American Diabetes Association—Colorado Affiliate

32nd Annual Colorado Diabetes/Endocrine Institute

January 20-25, 1996

Aspen-Snowmass, Colorado

Contact: Becky Burtis 303-778-7556

Colorado Society of Osteopathic Medicine

Advanced Cardiac Life Support Course

February 24-25, 1996

Keystone Lodge & Resort

15 hours AOA Category 1-A CME credit

Contact: Patricia Ellis at 303-322-1752

Colorado Society of Osteopathic Medicine

Ski & CME Midwinter Conference

February 25-March 1, 1996

Keystone Lodge & Resort

38 hours AOA Category 1-A CME credits; AAFP prescribed course hours

Contact: Patricia Ellis at 303-322-1752

American College of Cardiology

Workshop on 2-D and Doppler Echocardiography
February 26-29, 1996

Vail, CO.

18 Category 1 AMA

Contact: 800-257-4739

American College of Cardiology

The 3rd Annual Echocardiography Workshop
March 26-29, 1996

Vail, Colorado

Contact: 800-257-4739

Prosper Meniere Society

Annual Winter Meeting and the 5th Symposium on Inner Ear Medicine and Surgery

March 1996, Aspen, CO.

Contact: Jane Wells or I. Kaufman Arenberg,
MD.(303)778-4235

Society for Computer Applications in Radiology

Symposium in Computer Assisted Radiology
June 6-9, 1996

Denver, Colorado

703-716-7548

International Meniere's Disease Research Institute

9th Annual Electrocochleography/Otoacoustic Emissions/Intraoperative Monitoring Seminar

Summer 1996, Denver, CO.

AMA and ASHA CEU's offered

Contact: Jane Wells or I. Kaufman Arenberg,
MD.(303)778-4235





Joel M. Karlin, MD
President, 1995-1996

It is time to let the public know.

The Colorado Health Data Commission was sunsetted earlier this year by the Colorado Legislature. Does that mean that the issue of data will disappear? Far from it, and justifiably so. Those who buy health insurance, primarily the employers and the government, want information upon which to base their purchasing decisions. In this regard, the employers have begun discussing ways in which this endeavor might be shaped. One group of employers calls for a resurrected, more powerful, mandated data commission while another group looks at a private data initiative, where an employer-provider coalition could be developed to work cooperatively in collecting and interpreting data without government intervention.

In order to prepare the Colorado Medical Society to be at the table when these discussions are happening, I have been working with our CMS Data Committee over the last several months. This very effective committee was directed to look at two specific areas: evaluation of private data initiatives in other states, and physician-specific data. Physicians in other communities have participated in similar efforts. The Cleveland Health Quality Choice Program has created a model where employers, physicians and hospitals have worked together effectively over the last two years. Their system has evaluated two dimensions of hospital care: patient care outcomes and patient satisfaction. Such evaluations have been performed with input from physicians and

hospitals using validated methods for data collection. Information presented to the public includes severity adjusted lengths of stay and mortality rates for different medical conditions. Cleveland businesses use this information to identify high quality hospital services, and then provide incentives to their employees to use those cost effective institutions with the best quality ratings. Unfortunately, the Cleveland effort does not look at outpatient data. Analyzing different private initiatives and melding the best features of each could enable CMS to assist those leading the current efforts in the development of a potential ... "Colorado model".

It is clear to me after numerous discussions that if CMS is to be an active participant in both the design and implementation of any new data initiative, we will be asked to participate in the provision of physician-specific data (PSD). Not only are the employers and government vocal on this issue, but the general public wants this information, too. Please witness the public furor in the last two months regarding reporting of unexplained hospital deaths. To guide us in such an effort, the CMS Data Committee has looked into this sensitive issue, and made the following recommendation:

CMS should promote and participate in supporting high quality data collection efforts which focus on health care outcomes and which have the potential for improving the quality of care provided to our patients. Our primary mission should be 1) to represent physicians in ensuring the integrity of data. Data

"We have the opportunity to help develop those systems which will provide meaningful information to the public.."

PRESIDENT'S LETTER

(Continued)

must be responsibly collected and utilized; 2) the dissemination of information to physicians in support of continuous quality improvement. It is vitally important that CMS assist physicians in understanding how to use available data to determine whether change is warranted in their practice behavior; and 3) to support and facilitate consumer access to meaningful information about health care providers.

Initially, we will look at making already available data more accessible to the public. Patterned after a similar bill written by the Massachusetts Medical Society, the CMS House of Delegates reviewed RES-31P at their recent meeting and referred it to our Health Affairs

Council for action. It would facilitate public access to information regarding a physician's education and practice setting, and Colorado Board of Medical Examiner's disciplinary actions.

In discussing the issue of PSD with employers, we have inquired as to the type of data they would want. Technology is not yet available to produce meaningful, reliable, and valid outcome data for individual physicians. But we will work carefully to implement some mechanism to facilitate consumer access to meaningful information about physicians. You can rest assured, however, that we will proceed cautiously, and not repeat the early mistakes of at least one managed care company which inappropriately used incomplete global data to sanction many physicians.

We have the opportunity to help

develop those systems which will provide meaningful information to the public. It is our duty to make sure it is done correctly. If we want to eventually put the patient back in control of the health care delivery system, we will need to first give them the information to use.

Next month, I will share with you some thoughts I have on how we might assist in educating the patient and employer in using information to make informed choices of different health care delivery systems and the providers of that care.

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000

New Colorado Appellate Court Medical Malpractice Ruling

The Colorado Court of Appeals recently handed down its decision in the case of *Bilawsky v. Faceehudin and others*. A nerve in plaintiff's foot was severed during foot surgery. Defendants included the surgeon, anesthesiologist, and surgical residents observing the surgery. The non-surgeon defendants filed affidavits with the court stating that they had not taken part in the actual surgery on plaintiff's foot and therefore, could not have been responsible for the injury. Plaintiff then signed a stipulation dismissing those defendants; however, she later filed a pleading with the court to amend her complaint to rejoin them as parties because the surgeon refused to stipulate that he would not name them as non-parties at fault. Ultimately, the plaintiff dismissed those defendants when the surgeon finally agreed to sign the stipulation.

The dismissed defendants requested an award of their attorney's fees against the plaintiff and her attorneys for groundless and frivolous litigation. They

claimed that plaintiff and her attorneys had failed to conduct an investigation before filing the complaint and had not presented credible evidence that the defendants had committed any wrongful act. Plaintiff's attorney essentially admitted to such claims. The trial court awarded the anesthesiologist his attorneys' fees and costs but denied such request by the surgical residents as there was some evidence that the surgical residents had in fact assisted in plaintiff's surgery. It was undisputed that the plaintiff's attorneys did not obtain a certificate of review which is required by Colorado law in every action for damages based upon alleged professional negligence. The law requires that plaintiff's attorney must file such document for each licensed professional named as a party indicating that, based on known facts relevant to the allegations of negligent conduct, the filing of the claim does not lack substantial justification. The trial court found that plaintiff had failed to present any credible evidence to support her claim against the anesthesiologist and that the plaintiff's attorneys (1) made no effort to determine the validity of plaintiff's

claim in the 10-month period before filing the complaint, (2) failed to dismiss those claims which were not supported by the evidence, and (3) failed to depose any of the physicians or witnesses to the surgery.

The appellate court noted that a trial court must consider, in making a determination that a defendant is entitled to an award of attorneys' fees, whether any effort was made to determine the validity of any action or claim before the action or claim was asserted. It held that effort must be undertaken after the commencement of an action to reduce the number of claims or defenses being asserted or to dismiss claims or defenses found not to be valid within an action, and that facts must be evaluated to see what was available to a party in determining the validity of the claim or defense.

For further information please contact:
A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling, P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000



*Sandra L. Maloney
Executive Director
Colorado Medical Society*

Managed care is always a key component of any health reform proposal before Congress or the Colorado General Assembly. Policy-makers view managed care as a means of limiting the overall costs of health care by controlling individual access to and utilization of services. Many physicians, however, are skeptical about the promises of managed care and are concerned about its effects on their practice styles and the health of their patients. As a result, many of you are looking to CMS for support and assistance. Responding to the concerns of our members in this changing environment represents a major challenge.

In May, 1995, my article in *Colorado Medicine* identified several areas of potential services. The main categories were 1) education and information, 2) helping individual physicians or groups with problems through consulting services, and 3) development of a physician network. Obviously we have accomplished the development of a physician network with the creation of the Colorado Physician Network, Inc. and their related joint venture with Rocky Mountain HMO. I still need input from you on the first two items I presented.

At the recent Annual Meeting, we asked for the attendees to complete a survey which would give us a better sense of the services CMS should provide to its members. The number of responses was very low. It should be noted however, that managed care has been identified as the first area of concern. In addition to asking the respondents to identify

the major area of concern, we also asked them to identify preferences to address these issues. The top five responses, listed in order of priority, are 1) articles in *Colorado Medicine*, 2) in-house expertise available to respond to questions from the membership, 3) seminars, 4) resource referral, and 5) consultant referral.

Mr. David Ginsburg, consultant to CPN, offered the following ideas which are divided in three areas. These could be potential services for you, a member of CMS.

1. Integrated Delivery Systems

• What is an IDS?

Description of an IDS, including PHOs, MSOs, IPAs, specialty networks, integrated groups including group practice without walls and fully integrated groups, and foundation models.

• Evaluation of IDS models

Explanation of basic characteristics, pros and cons of each different type.

• Evaluation and Selection of an IDS.

Identification of key criteria physicians should consider in an evaluation of an IDS.

• Practical Issues in an IDS Relationship.

Understanding mergers and acquisitions.

How to value your practice.

• Successful Strategies for Integrating • Tools for Evaluating Agreements and Contracts with an IDS.

2. Basic Primer to Survive in a Managed Care Environment.

• What is managed care?

• Distribution of funds in a managed

"Where do we go from here?"

"Which programs would be most helpful to you?"

(CONTINUED)

EXECUTIVE DIRECTOR'S UPDATE

(CONTINUED)

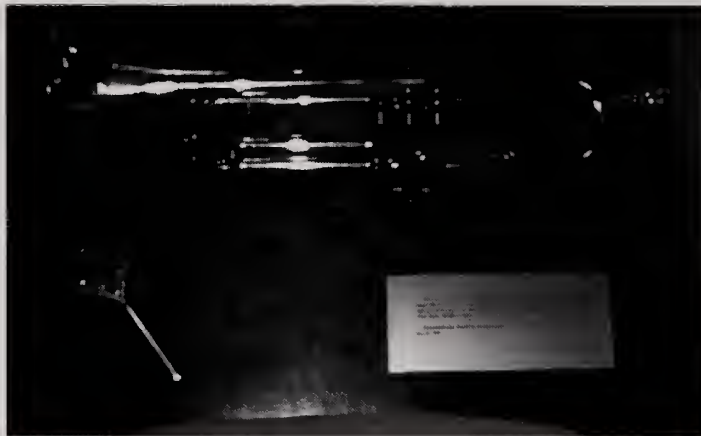
care environment.

- Understanding capitation.
How to negotiate a favorable rate.
- Why do we need utilization management?
- Effective UM systems.
- Keys for improving office efficiency with managed care patients.

3. Quality Assurance and Utilization Management and the medical practice.

- Understanding quality assurance and quality management.
- A close look at federal and HMO requirements.
- What is HEDIS and how can it help you in your practice?
- Patient satisfaction.
Designing patient satisfaction surveys.
- Winning in the utilization management world.
Explanation of the elements of physician profiling, understanding your report card.
- Practical tools for improvement of patient satisfaction, especially managed care patients.

Where do we go from here? Which programs would be most helpful to you? Again, we desperately need your input. Before we can develop an infrastructure at CMS or recommend the establishment an separate educational arm, we must know what services you need. How should we actively support CMS members so you can optimize patient care and practice successfully in the managed care environment? I await your thoughts.



It was an unusual plaque, but, hey, it was an unusual year. The CMS staff got together and came up with one of Dr. David Martz's favorite non-medical subjects (the trumpet), and went from there. The plaque was given in appreciation for Dr. Martz's year as President and in recognition of his working relationships with the staff members. The trumpet looks as though it had been through a number of campaigns and always at the front.

The inscription on the plaque reads:

"There were a few bumps and grinds; we marched into a couple of walls and took our lumps. He was able to hold the band together, though. We even ended all on the same note and were in harmony for most of the year, thanks to the direction and leadership of our **'First Horn'**, David C. Martz, MD, President, Colorado Medical Society, 1994-1995.

Presented to Dr. Martz by an appreciative Executive Director and staff, September 10, 1995"

Sandra L. Maloney



ONE FOR THE OTHER
Be a part of the whole:
Join COMPAC Today!



This concerns every physician in Colorado!

Colorado Medical Society is faced with the promulgation of new rules regarding physicians performing independent medical examinations (IMEs). In order to develop CMS policy on the issue, CMS membership opinions must be gathered.

One current issue chiefly concerns physicians performing IMEs for Workers' Compensation cases and auto no-fault insurance claims. This issue is, simply stated: "Should the State Division of Workers' Compensation IME physician panel require that the physician be in active practice? If yes, what percentage of his/her time?" The state regulations presently require that the physician be in active clinical practice at least 384 hours.

Another issue concerns the retired physician who continues to perform IMEs:

"Should retired physicians be allowed to continue performing IMEs for a time following retirement from active clinical practice?"

Again, we need your input, even though you may never perform an IME. The likelihood of this kind of rule-making trickling down into every level of medical practice is quite high. That is why developing a CMS policy on the matter is necessary. Your input is extremely important.

Please complete the attached card and drop it in the mail. Give us your honest opinion. We'll see it reflected in the making of CMS policy.

Doctor, please answer these vital questions and return the card to CMS as soon as possible!

1. "Should the State Division of Workers' Compensation IME physician panel require that the physician be in active practice?"
Yes ☐ No ☐
2. If you answer "Yes," what percentage of his/her time? _____ %
3. "Should retired physicians be allowed to continue performing IMEs for a time following retirement from active clinical practice?"
Yes ☐ No ☐
4. If you answer "Yes," what is an acceptable length of time? _____

YOUR opinion matters!

Make it count!

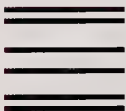
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1995-96 Colorado Medical Society Committee and Council Appointments

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Tom Allen, MD, Larimer County
Elaine Scholes, MD, Denver
George Shanks, MD, Mesa County
Muryl Laman, MD, Pueblo County

Finance Committee (three at-large members)

Bob Kruse, MD, Arapahoe
Susan Sherman, MD, Aurora/Adams County
Sherri Laubach, MD, Clear Creek Valley

Treasurer

Terrance J. Sullivan, MD, Denver

Organizational Study Committee

John Farrington, MD, Boulder County, Chair
J. R. Hanson, MD, El Paso County
K. Mason Howard, MD, Arapahoe
Richert E. Quinn, Jr., MD, Weld County
John A. Sbarbaro, MD, MPH, Denver
Ronald E. Tegtmeier, MD, Clear Creek Valley

Patient Advisory Committee

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Nathan Josephs, DO, Boulder County
Robert B. Sawyer, MD, Denver
Elaine Scholes, MD, Denver
Louise McDonald, MD, Denver

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Thomas, A. Carey, MD, Arapahoe
Tommie Cooper, MSC, Rose Medical Center
Tom Davis, MD, Penrose-St. Francis Healthcare System
George Kandel, MD, Denver
James G. Mann, MD, Clear Creek Valley
Susan Miller, Board of Medical Examiners
Frank Traylor, MD, Clear Creek Valley
Marc M. Treihaft, MD, Denver
Paul Wall, MD, El Paso County
Deb Van Houten, RN, FHP
Kathleen Root, RN, FHP
Carol Walker, El Paso County
Sue Radcliff, CPHP

Ex-Officio

Joel Karlin, MD, CMS President
M. Ray Painter, MD, CMS President-elect
cc: Dean Sadler, MD, Chair, Health Affairs Council
Lorraine Heth, CMS Staff

Health Affairs Council

Dean Sadler, MD, Clear Creek Valley, Chair
Richard Allen, MD, Chair of Council on Legislation
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Ned Calonge, MD, Denver
Patricia Byrns, MD, Denver
Jerry Chase, MD, Larimer County
Joel Levine, MD, Denver
Charles Mains, MD, Clear Creek Valley
Ron Tegtmeier, MD, Clear Creek Valley
Paul Visconti, MD, Aurora Adams County
Mark Wallace, MD, MPH, Denver

CMS Education and Research Foundation

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Terrance J. Sullivan, MD, CMS Treasurer
Sandra M. Finney, CMS
Nancy Kandel, CMS Alliance
Jerry Applebaum, MD, Denver

Council on Legislation

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Barbara Reed, MD, Denver
Joe Jarvis, MD, Aurora Adams County
Brian Johnson, MD, Resident Physician Section
Pam Laman, CMS Alliance
Jeremy Lazarus, MD, Arapahoe
Alethia Morgan, MD, Pueblo County
Lynn Parry, MD, Clear Creek Valley
Darrell Thatcher, MD, El Paso County
Chris Unrein, DO, Aurora Adams County

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J. Tashof Bernton, MD, Denver
Wyley Eaton, MD, Clear Creek Valley
L. Barton Goldman, MD, Arapahoe
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Fred Lewis, MD, Arapahoe
Ian Levenson, DO, Aurora Adams County
Brent Lovejoy, DO, Arapahoe
Kathryn Mueller, MD, Denver
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Karl Stecher, MD, Arapahoe
Richard L. Stieg, MD, Weld County
Dennis Waite, MD, Denver
Harold Yocum, MD, Clear Creek Valley

(Continued on following page)

1995-96 Colorado Medical Society Committee and Council Appointments

(Continued)

Health System Reform Task Force

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Richard L. Brownrigg, MD, Southeast Rural
Jerry Chase, MD, Larimer County
Richard Cohen, MD, Clear Creek Valley
Angie Heaton, MD, Aurora Adams County
Jeannie Kinzie, MD, Denver
Muryl Laman, MD, Pueblo County
Sherri J. Laubach, MD, Clear Creek Valley
Mark Levine, MD, Arapahoe
Louise L. McDonald, MD, Denver
Nelson Mozia, MD, Clear Creek Valley
H. Hugh Rohrer, MD, Arapahoe
Tom Schossau, MD, Resident Physician Section
David Schwartz, MD, El Paso County
Grant Steffen, MD, Arapahoe
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Data Committee

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Kenneth Kahn, MD, Boulder County
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A. Thomen Reece, MD, El Paso County
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Dennis Waite, MD, Denver

Task Force on Youth

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James Delaney, MD, Aurora/Adams
Richert Quinn, MD, Weld County
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Karyl J. Ting, MD, Clear Creek Valley
David W. Wells, MD, Aurora/Adams
Larry Wolk, MD, Denver

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Bill Doig, MD, Clear Creek Valley
John O. Cletcher, Jr., MD, Boulder County
Tom Hazy, MD, Denver
Mary Jo Jacobs, MD, Denver
Susan Jolly, MD, Arapahoe
Jeffrey C. Oram-Smith, MD, El Paso County
Gordon Tagge, MD, Larimer County

Rural Health Task Force

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Richard Allen, MD, Council on Legislation, Chair
Steve Batuello, MD, Resident Physician Section
Pat Clark, Medical Student Component Society
Donald Cline, MD, Southeast Rural
Dianna Fury, MD, Southwest Rural
Ousama Ghaibeh, MD, Southeast Rural
Douglas McFarland, MD, Southeast Rural
Richard Nicholas, MD, Northwest Rural
Mark Olson, MD, Northeast Rural
Edward Pino, MD, Southwest Rural
Andrew Saueracker, MD, Northeast Rural
George O. Thomasson, MD, Denver
Thomas Told, DO, Northwest Rural
S. Christopher Weaver, MD, Mesa County
Chester Wigton, MD, Southwest Rural

NOTE: If for any reason your name or affiliation is incorrect, or if your name is missing or misplaced on the list, please contact the CMS offices so that a speedy correction can be made.



M. Ray Painter, MD the President-elect of CMS



M. Ray Painter, MD
President-elect

In the closing session of the Colorado Medical Society House of Delegates at Aspen in September, M. Ray Painter, MD, of Glenwood Springs and Denver, was chosen as President-elect. He will succeed Dr. Joel M. Karlin in the office of President in September, 1996.

Ray Painter has been active in organized medicine for nearly his entire practice career. He began practice in 1970 in Glenwood Springs, Colorado, and continued there until 1994 when he moved to Denver. In 1990, Dr. Painter founded Physician Reimbursement Systems involved with physician coding.

Dr. Painter has served as a CMS delegate to the American Medical Association since 1989. He became a member of the CMS Council on Socio-Economics in the late '70s, and has served in a number of appointive positions since then. He headed the CMS Long Range Planning Committee for three years in the '80s and has been an active and vocal overseer of proper and ethical coding by physicians. He was involved in the development of the McGraw-Hill publication, *Relative Values for Physicians*.

Ray Painter also was re-elected as an AMA Delegate for CMS.

John L. Lightburn, MD, named CMS Historian

The CMS House of Delegates at its Annual Meeting named John L. Lightburn, MD, of Golden as CMS Historian. Dr. Lightburn is in semi-retirement and has reduced his practice. Dr. Lightburn says he is willing and has the time to take on the chore of trying to keep tabs on the CMS membership records. Staff support for the CMS Historian is provided by the Department of Communications and Member Services.

Dr. Lightburn is a Denver native and received his MD Degree from the University of Colorado. He was Medical Officer and Surgeon with the U. S. Public Health Service in Washington, D. C., for three years before entering general practice in Oregon and then returning to Denver to become Medical Director for the then Mt. Airy Sanitarium. He entered private practice in Denver in 1955 and continued until his recent semi-retirement. He has been a member of the American Psychiatric Association, the American Medical Association, and the Colorado and Denver Medical Societies. He was an instructor in Psychiatry at the University of Colorado and an Assistant Professor of Psychiatry at the CU School of Medicine.

Colorado Medical Society had, for many years, a very active archival library and active physician historian. When the Society was located in the Denver Medical

Library Foundation at 1601 E. 19th, the Historian, Dr. Bradford Murphey, recommended a complete re-cataloging of the Library. At that time, the library was scaled back considerably because it came on the heels of the Colorado Legislature making continuing medical education (CME) voluntary rather than mandatory. The CMS membership files were maintained principally for CME records and related credentialing purposes.

Prior to the advent of the computer, which occurred at CMS in 1978, all individual member records were kept in these files. Since that time, new member records are kept in computer storage. Though the computer is more efficient and space-conscious, member archives lack much of the historic charm they once offered up because of the wealth of press clippings and other information these "manual" files hold.

The physical archives were, as mentioned, reorganized and reclassified in the early 1980s, the materials reduced to 20 file cabinets containing approximately 17,000 individual physician files. The CMS Archives also contain *Colorado Medicine* and *Rocky Mountain Medical Journal* issues dating back to 1903, *Transactions of the Colorado (State) Medical Society* from 1894, *Proceedings of the CMS House of Delegates* and *Minutes of the Meetings* since the turn of the century.



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Price of the book is \$19.95 for AMA members, \$24.95 if you are not a member.

COMMITTEE UPDATE COUNCIL SECTION

The **WOMEN IN MEDICINE** Governing Council met October 11, 1995 under the direction of Dr. Mary Jo Jacobs. Dr. Jacobs reported that the legislative session will once again be facing the midwifery bill. The midwives are asking for prescriptive authority and to perform certain surgical procedures.

Debbie Bubnitz, M.D. reported on the election of CMS officers at the recent Annual Meeting. In connection with that meeting, the WIM section's Annual Meeting was held on Saturday, at the Aspen Center for Environmental Studies. The candidates for President-Elect spoke. Twenty-two people turned out for the meeting and tour of the center.

Sara VanScoy, M.D. served as the section's delegate and testified on a reference committee. The WIM's resolution regarding the support of voluntary HIV testing was adopted. Dr. VanScoy reported that the resolution regarding the length of hospital stays for obstetric delivery has been referred to the Health Affairs Council for further study. She also brought up the character based sex education resolution which endorses abstinence. This resolution has been deferred until the Interim Meeting. Dr. VanScoy will research information on this issue.

WIM Staffer Kirsten Spilde announced that she has taken the position of Network Administrator for the Colorado Physicians Network. She will continue to work for CMS for the next couple of weeks in transition. CMS will be hiring a replacement.

Dr. VanScoy reported on the Girl Scout Mentoring programming

noting that it is not a lengthy time commitment. Dr. VanScoy attended the orientation meeting on Oct. 10, 1995, with two other physicians and Kirsten Spilde. Only one student turned out for the meeting but Linda Fuller, Program Executive for the Girl Scouts, reported that she has four other interested students. A lengthy discussion on professional women and juggling career and family was discussed. The Girl Scout program would like for students to be able to interact, visit a physician's practice and be able to talk to the physicians. The physicians were concerned over the level of appropriateness for what students should see and the issue of confidentiality. A social meeting has been scheduled for Tuesday, Dec. 5, 1995, at 6:00 p.m. Dr. VanScoy will call Linda Fuller to discuss this program further. Kirsten Spilde will provide an updated list of interested physicians to Linda Fuller.

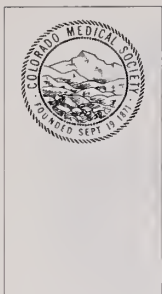
Ms. Spilde announced that a Chair-Elect needs to be elected and raised the possibility of having co-chairs to help current chair, Maura Lofaro, M.D., who is in a surgical residency. Dr. VanScoy was nominated to possibly fill or co-chair with Dr. Lofaro. One governing council seat is vacant and Anastacia Darrow, M.D., resigned. These discussions were tabled until further notice.

Ms. Spilde announced that the WIM planning meeting for the 1996 Leadership conference will be Thursday, Oct. 19, at 7:00 a.m. at the CMS offices. It was emphasized that letters need to be mailed as soon as possible asking companies for financial support of this conference.

A monthly report of current and ongoing activities of the Councils, Committees and Sections of the Colorado Medical Society. None of the information herein is meant to indicate a policy or position statement of the Colorado Medical Society. This report is designed only to inform CMS members of their organization's activities and study projects at the Council, Committee or Section level.

The WIM calendar was set for the next year. The meetings will begin at 6:00 p.m. and are as follows:

December 6, 1995
February 7, 1996
April 10, 1996
June 5, 1996
August 14, 1996



SCAM OF THE MONTH

The Colorado Prescription Drug Abuse Task Force

In 1982 Colorado ranked among the top 15 states in per capita consumption of five commonly abused prescription drugs. To counteract this abuse and misuse, the Colorado Prescription Drug Abuse Task Force was organized in 1984. This nonprofit corporation is a consortium of over 30 private and public health care, regulatory, and law enforcement agencies.

The following are "scams" that have been used on unsuspecting medical professional's in Colorado.

Awareness is the key. Educate yourself in the diversion tactics used most frequently, and become familiar with which drugs are popular for abuse and resale on the street. Report suspicious activities to the police and communicate with other physicians and pharmacists in the local community.

Clinical Diversion Scam

(This scam was perpetrated by a nurse whose husband was a psychiatrist and whose mother-in-law was also a nurse at a community hospital.)

The suspect, who was the head nurse at a plastic reconstructive clinic, was described as a "very competent, professional nurse", and had been in her position over five years.

The clinic for which she worked had a contract with a local nursing home. Whenever a patient from the nursing home would have surgery at the clinic, on an out-patient basis, the patient would be transported back to the nursing home by ambulance, along with whatever medications had been prescribed. On the return trip, the ambulance crew would bring the clinic any unused supplies or medications from the nursing home.

Part of the head nurse's responsibilities included accounting for these returned medications, as well as inventorying and ordering the clinic's own supply of medications. By falsely reporting the amount of returned medications, and some creative booking in the regular inventory (i.e., "broken container, shortages in incoming shipments, etc.), the nurse was able to divert considerable quantities of Demerol, Dilaudid, and Vicodin for her own use.

Even though colleagues eventually came to suspect the false ledger entries and shortages, the nurse's standing in the medical community

and her reputation enabled her to continue this diversion for nearly three years. In the end, even though the booking became sloppier and the diversion became more blatant, the diversion was not acknowledged by her family or colleagues, or confronted, until she overdosed and suffered a seizure.

(Submitted by Suzanne Reed and Marina Costilla, U.S. Drug Enforcement Administration, Denver, December, 1989)

Solutions for Scam

1. Checks and balances are vital when drugs are kept on hand. Proper inventories, complete with witnesses and random audits, are a necessary part of good office procedures. Rotate the responsibility of conducting inventories so no single person maintains complete control over the process of ordering and stocking supplies.

2. It is also important to realize that a person addicted to drugs will unintentionally use and abuse friendships and family and professional relationships to cover his/her actions. It is not an act of friendship or professionalism to ignore signs of addiction in a friend or colleague. Report suspicions of diversions to supervisors. This should be done confidentially, but immediately.

3. It should also be realized that, due to the popularity and high street value of these drugs, these precautions are even more necessary to help discover dishonest diversion on the part of persons without an addiction.



Dr. Steve Thorson Honored for Service to Medicine

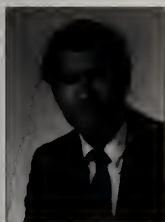
Steven J. Thorson, MD was awarded the 1995 Certificate of Service by 1994-1995 CMS President David C. Martz, MD at the recent annual meeting of the Colorado Medical Society. Dr. Martz recognized that Dr. Thorson brought wisdom, candor and determination to the table on behalf of his fellow physicians. He has served and continues to serve.

In bestowing this award, Dr. Martz noted that, "Through [Dr. Thorson's] labor and concern for his profession, the Colorado Medical Society members benefit from his contribution in fiscal, administrative

and legislative matters. Dr. Thorson has done an outstanding job for organized medicine."

Dr. Thorson has been a member of the Colorado Medical Society for 21 years. He specializes in Family Practice in Fort Collins and is a member of the Larimer County Medical Society. He has held numerous state and county offices, including, for several years, the office of treasurer of the Colorado Medical Society. It was in this position that he oversaw the retirement of the bond debt of the Colorado Medical Society and a new era of fiscal health.

Dr. Thorson received his medical degree from the University of Minnesota School of Medicine and did his residency at the Hennepin County General Hospital in the Minneapolis area.



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The CME Challenge: Are Physicians Learning Anything?

Lorraine K. Heth, Program Manager
Colorado Medical Society

This is the second of two articles written with the objective of reminding physicians that a personal commitment to lifelong learning is a key factor in maintaining high-quality patient care. Learning is a challenge. Are you choosing CME activities based on *real, identifiable* learning needs? Are you tuned into your learning style — Are you auditory, visual or kinesthetic? Are you asking CME staffers and Committee members to provide you with activities pertinent to your needs *and* learning style? In an effort to meet this challenge, what follows is information on how physicians can *actively participate* in changing their learning process.

Formal Educational Programs

Many institutions and organizations sponsor educational conferences, seminars, and workshops, at both the national and local level. Those who have demonstrated that they meet the basic standards for planning, presenting, and evaluating quality continuing medical education (CME) are accredited. While most physicians can easily identify a wide variety of accredited CME activities, selecting those that best meet their individual needs presents a greater challenge.

By following a logical sequence of steps, physicians can assess the

quality of the programs that are offered and make the best choices among them.

As a first step, physicians should look for certain designations that indicate quality CME. AMA Physician's Recognition Award (AMA PRA) Category 1 and Category 2 credit, the American Academy of Family Physician's (AAFP) Prescribed Credit and the American College of Obstetricians and Gynecologists' (ACOG) Cognates are such designations (and are viewed by the AMA as being equivalent). AMA PRA Category 1 and 2 can only be designated by organizations accredited by either the Accreditation Council for Continuing Medical Education (ACCME), or a state medical society. Physicians should always double-check the sponsor of a CME activity. Some organizations use the free-standing term "Category 1" for CME activities which do not meet the standards of the AMA PRA credit system and will not be accepted by the AMA PRA. The sentences to look for are:

1. *"The (name of sponsor) is accredited by the Accreditation Council for CME (or a State Medical Society) to sponsor continuing medical education for physicians."*
2. *"The (name of accredited sponsor) designates this continuing medical education activity for (#) credit hours in Category 1 (or Category 2) of the Physician's Recognition Award of the American Medical Association."*

Second, physicians should review the learning objectives of each offering and ask "Do they

match what I want or need to learn? The learning objective should be clearly stated in the informational material provided. If there are questions about the program's educational objectives, the physician should contact the sponsor and clarify any concerns.

The next step is to consider the reputation of the sponsor, the exact program content, the names and qualifications of the faculty, as well as the format and methods of instruction. A program that includes participatory methods, such as small group discussions, is generally a more effective CME activity than one that is primarily a lecture or presentation of papers.

Since physician satisfaction is also an important criterion for assessing the quality of the activity, word-of-mouth opinions are very useful in the evaluation process. The experience and recommendations of others who have previously participated in the program can be an important decision factor.

The final step is to evaluate the program's cost and location. If the conference meets the physician's learning needs, the location and the amenities that are included may offer important additional benefits. Opportunities for relaxation and recreation can help the physician (and perhaps other family members) return home refreshed in mind and body.

¹Bedard, M. WM Winter '93: "Hospital Libraries Are Your Gateway to Better Patient Care," pp 23-26.

²Cervero, RM, Azzaretto, JF & Assoc (1990). *Visions for the Future of Cont Prof Educ*. Georgia Center for Continuing Education, The Univ. of Ga.

Colorado State Science Fair Winners Receive Awards



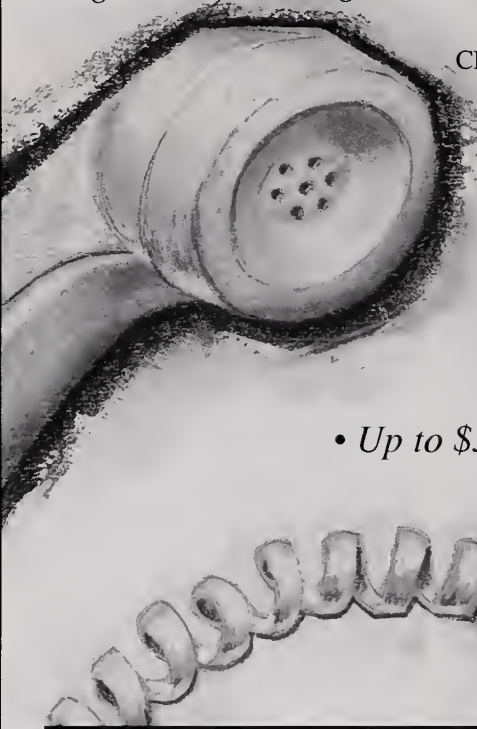
Gordon Tagge, MD of Fort Collins (left) joins CMS' incoming President Joel M. Karlin, MD (right) in congratulating Erin Rakowski of Durango (center) on her receipt of the Junior Division Award for a project dealing with medically-related issues at yhr 1995 Colorado State Science Fair. Dr. Tagge serves as the Colorado Medical Society representative on the board of directors of the Science Fair and served as one of the judges for the medical category.

Outgoing CMS President David C. Martz, MD congratulates fellow Colorado Springs resident Emily Bruger on winning the Senior Division Medical Category award at the Science Fair. Emily and Erin each received a US Savings Bond from the Colorado Medical Society and the opportunity to display the winning exhibit at the Annual Meeting in Aspen.



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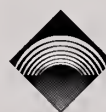
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AMA-HMSS moves into the future of managed care

The American Medical Association Hospital Medical Staff Section has now become the Organized Medical Staff Section. In a bylaws change approved at the Interim Meeting of the AMA House of Delegates, the mission of HMSS was broadened to include representation of physicians in physician-controlled, non-hospital organizations.

The OMSS established credentialing criteria at the August meeting of the Governing Council. A delivery system with a medical staff organization, network panel or group consisting of at least 50% practicing physicians/shareholders with a written document providing a process for the physicians to elect officers, conduct credentialing and peer review activities, and provide input into the utilization review and quality improvement programs will be eligible to send representatives to the OMSS meetings. An organization without the written document can send a provisional representative for one year (two meetings). There is no minimum number of physicians for an eligible organization.

Your physician organization is encouraged to elect a representative to attend the Interim Meeting November 30 – December 4 in Washington DC. Representatives must be AMA members, members of the medical staff or have clinical privileges, and be elected by the practicing physicians of the organi-

zation. Call Michael Vitek at 312-464-4757 or Lee H. McCormick, MD at 412-885-6330 for more information

HMSS Becomes OMSS

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RUMINATIONS

(**def:** chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

Look at this! This is great! This is a picture and article about honoring 50-year physicians. It's from the Denver Post, September 11, 1959, **36 years ago to the day** that we honored our 50-year physicians at the Colorado Medical Society Annual Meeting in Aspen this year.



PHYSICIANS HONORED FOR SERVICE

These three Colorado physicians were among six honored Thursday night at a banquet held by Colorado Medical Society in the Brown Palace Hotel, for their 50 years of service to the medical profession. From left: Drs. Harold T. Low of Pueblo, William Wiley Jones of Denver, and Winfield Scott Cleland of Delta. The other three were Drs. Amos L. Beighler and Harmon L. Fowler, both of Denver, and Bert Lee Adams of Fruito. Banquet was part of the 10th biennial Rocky Mountain Medical Conference.

New Careers at 60 Pictured By Specialist on Old Age

The day is not too far off when plans for retirement should be replaced by plans for a second career," said Dr. Bortz. Positive development of better health for individuals of all ages, he said, is the third great program which the medical profession now must undertake.

The prediction was made by "The medical profession to

"But, with advances of science in recent years, these are not the only objectives of the doctor," he said.

"Instead of dying, people will continue to live," he said, if medical men continue to succeed in reducing the rate of deaths caused by the following

I think it is wonderful that I still have this newspaper clipping and that these three men were not totally forgotten. It is vitally important that the physicians honored this year are not forgotten. It was a long list, and there were three who attended the meeting (*pictured at right*). These three are still very active in medicine and in CMS, as they have been for the majority of their years in practice.

I especially liked the article from that '59 Post discussing "New Career at 60..." by Dr. Edward Bortz. That is certainly not out of the question any more, and many of our physicians don't want to quit their professional pursuits, even at 65 or older. The accompanying article

about Dr. Theodore Klumpp of New York City, speaking to that CMS meeting, addressed the "fast-pace of modern living and over-eating" effect on long life. Dr. Klumpp said "Older people can live longer by leading an active, useful existence after retirement instead of 'rusting away'".

Klumpp added that "Our society has been quite illogical and inconsistent in its attitude toward the older worker," speaking of compulsory retirement. "On the one hand," Klumpp said, "it is apparent that we have no objection to electing and appointing older individuals to positions of the greatest responsibility in government, business and the professions. Often times, their careers are just starting at a time when society is systematically dumping others on the scrap heap."

Klumpp added that the death toll from heart attacks and "strokes" stems from increasing tensions and anxieties in modern society and from "labor-saving devices that enable man to avoid physical activity". He should be around today and see what life is like!

There are two very important aspects of life which, I think, the majority of people overlook: the **past** and the **future**. The past can give you very strong indications of where you're life is headed. The future is the proving ground for all those ideas you had in the past.



CMS President Dr. David Martz (far rt) is in the process of presenting three physicians with the CMS 50-year pin honoring each one's 50 years of medical practice. They are (l to r) Drs. Lynwood Hopple, Lynn James, and Harry Wherry. The ceremony was on September 11, 1995, at the CMS Annual Meeting.

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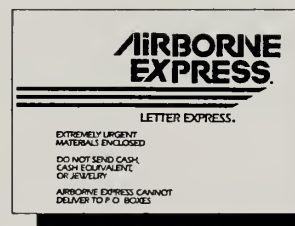
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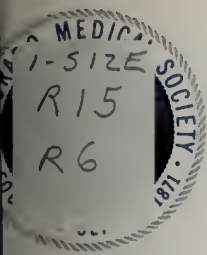
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CMS goes electronic on the Internet...
... can a *web* page be far behind?

Information begins on page 406



Colorado
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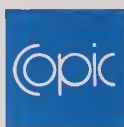
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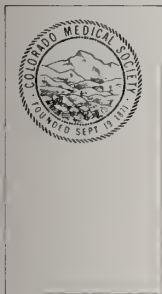
December, 1995

Volume 92, Number 12



Cover Story

CMS has always held communication with its members as a high priority. Now that priority moves onto the information superhighway. See page 406 and following.



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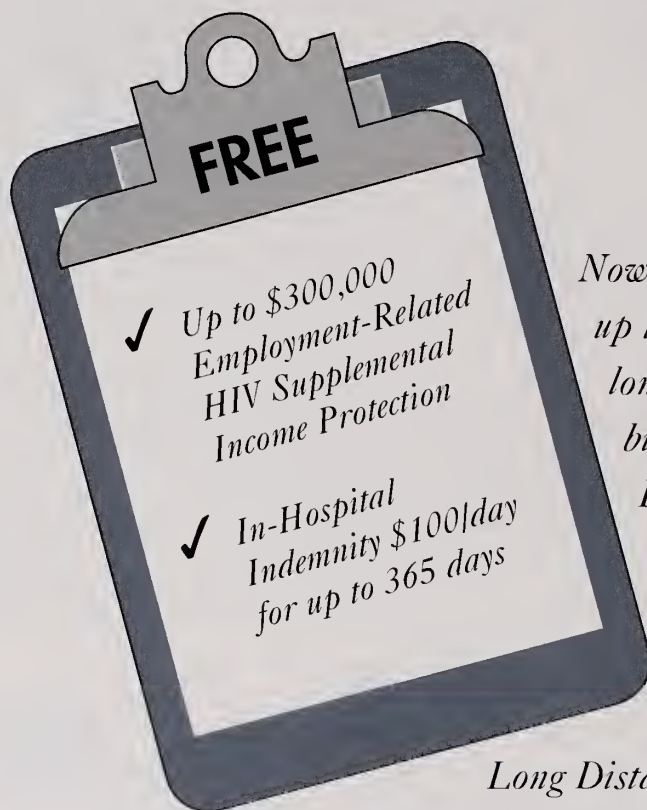
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CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press. **AT PRESS TIME...**

CMS Med Fax[®]
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

Workers' Comp Adopts New Fee Schedule

As of October 1, 1995, procedures performed under Workers' Compensation will be paid according to a revised fee schedule. Rule XVIII of the Colorado Workers' Compensation Rules of Procedure was amended to include the incorporation by reference of the December, 1994 edition of the *Relative Values for Physicians* (94.2) as published by McGraw-Hill, excluding the Physical Medicine and Rehabilitation Codes and Values (97000 series of codes).

The revised rules also refer to 1994 study, *Physicians as Assistants at Surgery*. General instructions as well as many service and procedure codes and fees not found in the RVP or RVD are also included in the new Rule XVIII.

You may obtain copies of these documents from:
Public Records Corp., 303-832-8262 (for Rule XVIII, containing general instructions, limitations and the Physical Medicine and Rehabilitation codes and fees.)

McGraw-Hill, 1-800-544-8168 (for *Relative Values for Physicians*. Specify the 94.2 edition and mention Colorado Workers' Compensation for a 10% discount.)

American College of Surgeons, Marcia Banks, 202-337-2701 (for *Physicians as Assistants at Surgery*)

If you have any additional comments or questions, call Debra J. Northrup, RN, Medical Cost Containment Supervisor at the Colorado Division of Workers' Compensation, 303-575-8761.

Workers' Comp Accreditation Seminars

The Colorado Division of Labor and Employment will be conducting accreditation seminars for physicians who wish to perform impairment ratings for work-related injuries. Physicians who were originally accredited during the period of January to May, 1993 should have received information on a re-accreditation seminar to be held January 26 and 27, 1996.

Physicians who are not yet accredited to perform impairment ratings may attend the Level II Seminar on February 9 and 10, 1996. This seminar includes lectures and workshops led by specialty experts on the administrative and legal aspects of the workers' compensation system and educates physicians on formulating impairment ratings utilizing the AMA Guides. For information on either of these seminars, call Faye Boyd, 303-575-8756.

CHAMPUS Pre-authorization requirements

Physicians who provide OB/GYN services under CHAMPUS should be aware that pre-authorization is required for inpatient abortions, hysterectomies and cesarean sections. Pre-authorization must be obtained no more than thirty days and no less than two days before the procedure, unless it is urgent or emergent. In

that case, you have two working days afterward to obtain authorization.

If this authorization is not obtained, the case may be subject to review and/or penalties. Call 1-800-783-2477 M-F 5 am to 5 pm or FAX 1-800-431-2565 for pre-authorization or more information.



Med Fax: Medico-Legal News

by David A. Burlage, Esq.,
Shareholder, and Karen B. Best,
Esq., an Associate with the law firm
of Montgomery Little & McGrew, PC.

*This column is not legal advice, but is for general
information only. For help with specific problems,
readers should consult an attorney.*

This is the second of two articles dealing with sexual misconduct as a form of unprofessional misconduct which may subject the physician to sanctions, including suspension and revocation of licensure.

SEXUAL MISCONDUCT BY HEALTHCARE PROFESSIONALS:

THE LICENSING PERSPECTIVE - PART II

ETHICAL CONSIDERATIONS

In its Sexual Misconduct Statement adopted in November of 1993, the Colorado State Board of Medical Examiners encouraged and strongly recommended adherence to the following ethical guidelines:

1. Physicians must respect a patient's dignity at all times and should provide appropriate gowns and private facilities for dressing, undressing and examination. In most situations, a physician should not be present in the room when a patient is dressing or undressing.

2. A physician may wish to consider having a chaperon present during examination of any sensitive parts of the body for protection of both the patient and the physician. A physician should refuse to examine sensitive parts of a patient's body without a chaperon present if the physician believes the patient is sexualizing the examination.

3. To minimize misunderstandings and misperceptions between a physician and patient, the physician should explain the need for each of the various components of an examination and for all procedures and tests.

4. Physicians should choose their words carefully so that their communication with a patient are clear, appropriate and professional.

5. Physicians should be alert to feelings of sexual attraction to a patient and may wish to discuss feelings with a colleague. To maintain the boundaries of the professional relationship, a physician should transfer the care of a patient to whom the physician is attracted to another physician and should seek help in understanding and resolving feelings of sexual attraction without acting on them.

6. Physicians must be alert to signs indicating that a patient may be encouraging a sexual relationship and must take all steps necessary to maintain the boundaries of the professional relationship including transferring the patient.

7. Physicians should not discuss their intimate personal problems or lives with patients.

8. Physicians should seek out information and formal education in the area of sexual attraction to patients and sexual misconduct, and should in turn educate other health care providers and students.

Standards setting boundaries between psychologists and clients are also informative. The American Psychological Association's Council of Representatives has adopted and periodically has revised "Ethical Principles of Psychologists and Code of Conduct." This document applies to psychologists, to students of psychology and to others who do work of a psychological nature under the supervision of a psychologist. The document is intended to provide standards of professional conduct.

The Committee on Professional Standards of the American Psychological Association has published "Specialty Guidelines for the Delivery of Services," Approved June, 1981.

The Board of Professional Affairs, Committee on Professional Standards, of the American Psychological Association has published "General Guidelines for Providers of Psychological Services," approved as of February, 1987.

REGULATORY DEVELOPMENTS

In November, 1993 the State Board of Medical Examiners issued its "Sexual Misconduct Policy" which provides in pertinent part as follows: Sexual contact with a patient is sexual misconduct and is a violation of § 12-36-117(1)(r), C.R.S. A sexual act is defined as a sexual contact, sexual intrusion, or sexual penetration. Section 18-3-401, C.R.S. defines sexual contact, sexual intrusion, sexual penetration and intimate parts. "During the course of patient care" encompasses all sexual acts between the physician and patient during the period of time a physician-patient relationship exists and not just during times of actual examination or treatment.

TERMINATION OF THE PHYSICIAN- PATIENT RELATIONSHIP

The determination of when a person is a patient for purposes of § 12-36-117(1)(r), C.R.S. is made on a case-by-case basis with consideration given to: The nature of the professional relationship; The extent of the professional relationship; and the context of the professional relationship. The fact that a person is not actively receiving treatment or professional services from a physician is not determinative of this issue. A person is

Continued on following page...

Medico-Legal News

From previous page

presumed to remain a patient until the physician-patient relationship is terminated

The physician has the burden of showing the physician-patient relationship no longer exists. Factors the BME will consider in determining whether the physician-patient relationship has been terminated include: the passage of time since the last visit; any formal termination procedures carried out; a transfer of the patient's care to another physician; reasons for terminating the professional relationship; the extent to which a patient has confided personal information to the physician; the nature of a patient's medical problem; the degree of emotional dependence by the patient on the physician; and the extent of the physician's general knowledge about the patient.

A patient's consent to, initiation of or participation in sexual behavior or involvement with a physician does not change the nature of the conduct nor lift the statutory prohibition.

IMPAIRMENT OR MENTAL

DISABILITY OF THE PHYSICIAN

Many Boards now believe that a physician or other health-care provider's sexual involvement with a patient may be the result of a mental disability or impairment. Increasingly, these Boards are requiring the licensee to undergo an evaluation, the purpose of which is to assess, classify and determine whether licensees who have had sexual contact with their patients can be

rehabilitated such that they pose no threat to the public health, safety or welfare.

The evaluation process, modeled after the process proposed by Gary R. Schoener classifies licensees into one of the following six categories: (1) Uninformed and naive; (2) Healthy or mildly neurotic; (3) Severely neurotic; (4) Character disorders with impulse control problems; (5) Sociopathic or narcissistic character disorders; or (6) Psychotic or borderline personality disorders. See: Gary Richard Schoener and John Gonsiorek, "Assessment and Development of Rehabilitation Plans for Counselors who Have Sexually Exploited Their Clients," *Journal of Counseling and Development*, December, 1988. Vol. 67, pp. 227-232

There is a heightened awareness by both the consuming public and Board members of the occurrence of sexual misconduct within the professional relationship. Administrative trends show an increasing level of disciplinary activity which is becoming more severe (revocation or significant length of suspension), coupled with more requests for psychiatric and psychological evaluation.

CONCLUSION

The physician must be ever mindful in the first instance of the Hippocratic Oath, and failing that, ever conscious of the severe licensure sanction, as well as civil liability, awaiting those who violate the Medical Practice Act or the standards of professional practice by overstepping the boundaries between physician and patient.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

International Meniere's Disease Research Institute

7th Annual Interdisciplinary Seminar on Diagnostic and Rehabilitative Aspects of Dizziness and Balance Disorders.

December 6-10, 1995, Denver, CO.

Contact: Jane Wells or I. Kaufman Arenberg, MD.(303)778-4235

American Brachytherapy Society

Annual Mid-Winter meeting

"Brachytherapy: The First Hundred Years"

December 10-13, 1995

Hyatt Regency Scottsdale at Gainey Ranch, Scottsdale, AZ.

Contact: (215) 574-3158

American College of Cardiology

The 27th Annual Cardiovascular Conference at Snowmass(1617)

January 15-19, 1996

Snowmass,Colorado

Contact: 800-257-4739

American Diabetes Association—Colorado Affiliate

32nd Annual Colorado Diabetes/Endocrine Institute

January 20-25, 1996

Aspen-Snowmass, Colorado

Contact: Becky Burtis 303-778-7556

The Eleventh Annual Rocky Mountain Regional Conference on HIV Disease

February 1-3, 1996

Red Lion Hotel

Denver, Colorado

Contact: Colorado AIDS Project, Attn: AIDS Conference, P.O. Box 18529, Denver, Colorado 80218, or call (303) 837-0166

Colorado Society of Osteopathic Medicine

Advanced Cardiac Life Support Course

February 24-25, 1996

Keystone Lodge & Resort

15 hours AOA Category 1-A CME credit

Contact:Particia Ellis at 303-322-1752

Colorado Society of Osteopathic Medicine

Ski & CME Midwinter Conference

February 25-March 1 , 1996

Keystone Lodge & Resort

38 hours AOA Category 1-A CME credits; AAFP prescribed course hours

Contact:Particia Ellis at 303-322-1752

American College of Cardiology

Workshop on 2-D and Doppler Echocardiography at Vail

February 26-29, 1996

Vail, CO.

18 Category 1 AMA

Contact: 800-257-4739

American College of Cardiology

The 3rd Annual Echocardiography Workshop at Vail March 26-29, 1996

Vail, Colorado

Contact: 800-257-4739

Prosper Meniere Society

Annual Winter Meeting and the 5th Symposium on

Inner Ear Medicine and Surgery

March 1996, Aspen, CO.

Contact: Jane Wells or I. Kaufman Arenberg, MD.(303)778-4235

Society for Computer Applications in Radiology

Symposium in Computer Assisted Radiology

June 6-9, 1996

Denver, Colorado

703-716-7548

International Meniere's Disease Research Institute

9th Annual Electrocochleography/Otoacoustic Emissions/Intraoperative Monitoring Seminar

Summer 1996, Denver, CO.

AMA and ASHA CEU's offered

Contact: Jane Wells or I. Kaufman Arenberg, MD. (303)778-4235



PRESIDENT'S LETTER



Joel M. Karlin, MD
President, 1995-1996

Last month I detailed for you my deep felt conviction that we as physicians have the duty to provide information to the public by which they may make informed decisions as "health care consumers".

My "ideal" health care delivery system has the patient selecting and owning their health insurance plan. For over 15 years, federal civil service employees have been given the choice to pick their insurance plan from a list of over 40 plans, covering all possible health care delivery systems. The government has supplied them with a fixed contribution each month, and the employees have used that health care voucher to select the plan that works best for their individual and family needs. Does this system work? You bet it does! During the last 14 years when the annual rate of health insurance inflation has exceed 14%, the Federal Employees Benefit Plan has risen merely more than 6% per year. True competition is the market place at the individual patient level, and it works!

In June, 1995, CMS invited representatives of large and small employers, the insurance brokerage community, and the Alliance (the first Colorado Cooperative for Health Insurance Purchasing, or CHIP) to meet and discuss their perspectives on issues of common interest. This Focus Group on Health Care Issues has met twice monthly since inception. Surprisingly, they all agree that a patient-driven system has the potential to solve many of the problems currently encountered in our employer-based system. One major concern was voiced by all participants: most individuals do not possess the knowledge necessary to make informed choice. I believe that we must provide the public with the knowledge base and resources necessary to make such decisions. As additional health plan and provider specific data become

available, people need to know where to access this information, and how to use it. CMS believes in a pluralistic health care delivery system. The public has the right to know, in an unbiased fashion, both the positive and negative features of all systems and participating plans. Armed with such information, they will force market changes which will first benefit patients. That's the way it should be!

This need for public education may become acutely evident in the short term if the Congressional plans for Medicare transformation, including the creation of both the Medicare choice program and Medical Savings Accounts, are implemented. If Medicaid becomes a state block grant program, the Governor and State Legislature will most likely look at creating a new system involving greater patient responsibility and choice.

Most people obtain their health insurance through their place of employment. Self-employed individuals will be able to join CHIPs beginning January 1, 1996. Other individuals may be extended similar rights in the near future. The tax treatment both employers and employees receive on employer contributions for the purchase of health insurance at the workplace currently makes it almost impossible for most employees to purchase health insurance elsewhere. Congressional leaders plan to address this issue early in 1996. They will attempt to pass legislation which will permit the same tax treatment for employers and employees to either purchase health insurance at

continued...

President's Letter...

the place of employment or use the benefit to purchase such insurance through other vehicles.

I believe that there is a great need to create a mechanism to educate both individuals and employers on health care related matters. Such an "Educational Venture" could best be created with the help of all interested parties: employers, health care providers, insurers, patient groups, and the state government.

Initial discussions relating to such an Educational Venture have met with acceptance from the employer community, the Governor's staff, Colorado legislative

leaders, insurers, and other health related groups. Many of these groups have already begun working on parts of this problem. I believe that economy of time and resources could be achieved through collaboration and creation of a potential educational foundation supported by all interested parties. To such an end, we are facilitating the discussion by inviting these groups to an exploratory meeting to determine the interest level and willingness to participate in such an endeavor.

These are exciting times with such great opportunities for us to help shape the future of health care delivery in Colorado. We have the

opportunity to again be national leaders, this time in assisting in the creation of their first such model of cooperation between these interested groups.... all for the benefit of our patients.

LEGAL UPDATE

Are You Fully Covered?

Personal and business insurance are tools for preserving and protecting assets. Check your policies of insurance to determine if you are adequately protected.

One particularly useful asset protection tool is the "umbrella" or excess coverage policy to provide excess coverage in business and personal activities. Should you be found negligent for an accident that occurs at your home or in your automobile, umbrella coverage will provide an additional layer of protection beyond your standard liability policy. Many professionals are aware of umbrellas and have been utilizing them for many years. What is unusual and, to some insurance carriers, new, is uninsured motorist coverage as part of your umbrella policy.

Should you be involved in an accident and the other driver involved has no insurance, uninsured motorist coverage protects you. A recent insurance check point in the Denver area showed that one in four drivers had no insurance. Unin-

sured motorist coverage also protects you when your vehicle is struck by a person carrying inadequate insurance to compensate you for injuries and damages you or a family member sustain. So long as the amount of your uninsured/underinsured motorist coverage is greater than the insurance coverage of the at-fault driver, you will have the opportunity to recover from your own insurance company. If your umbrella coverage also extends to your uninsured motorist coverage, you and your family will have much higher and broader protection.

A preferred umbrella policy provides protection not only in an every day situation, but also when you are injured by an uninsured motorist. Many insurance carriers do not sell umbrellas that feature the uninsured/underinsured motorist protection. It is essential for you to have that coverage. Please review your specific policy. If it does not have uninsured/underinsured motorist coverage, please contact your agent and see if or how it can be added. Generally, it is inexpensive.

Without sufficient uninsured motorist

coverage or umbrella protection, the following scenario could occur. You are walking across a street and another driver runs a red light, strikes you and permanently disables you. The driver has no insurance. You are only carrying \$25,000 pre person, \$50,000 per event in uninsured motorist coverage. Your umbrella policy does not cover uninsured motorists. All you can recover are benefits available under the Colorado No-Fault statute and \$25,000 in uninsured motorist coverage benefits, leaving your family in significant financial difficulty. Carrying uninsured motorist coverage in your underlying policy or through an umbrella can provide the resources you need to protect your family.

For further information please contact: A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

*from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000*

TO: Colorado Medical Society members

We are attempting to garner information from patients concerning issues of importance to our planning and legislative pursuits on your behalf. We would appreciate your office staff copying the survey below and distributing it to your patients and sharing the results with our offices.

"What are your thoughts?"

Dear patient:

Please complete this survey and return it to the receptionist.

Our entire staff will appreciate your help in improving our service to you, the patient.

1. Do you have health insurance? yes ☐ no ☐
2. If the answer to question 1 is "yes", is that insurance:
a) Medicaid? ☐ b) Medicare? ☐ c) private insurance? ☐ d) other? ☐
3. If you have private insurance, where do you obtain insurance?
a) group policy at work? ☐ b) individual policy? ☐ c) other? ☐
4. If you have insurance through your work, does your employer give you a choice of more than one health plan? yes ☐ no ☐ N/A ☐
5. If you have insurance through your work, does your plan provide you with the option to go out of plan to choose your physician? yes ☐ no ☐ N/A ☐
6. If you have insurance through your work, does your employer pay:
a) entire premium? ☐ b) a fixed dollar amount? ☐
c) a percentage of premium? ☐ d) no contribution? ☐
7. Is choice of your physician important to you? yes ☐ no ☐
8. If choice of physician is important to you, would you be willing to pay a higher monthly insurance premium for that choice? yes ☐ no ☐

It is not required, but you may sign your name if you choose. Thank you.



Colorado Medical Society, and "on-line" services for the physician's office

by Timothy H. Roberts, Director
Division of Membership Information Services

Colorado Medical Society is now accessible via the Internet. A listing of staff Internet electronic mail addresses is included.



To communicate with us electronically, you must have access to the Internet with your own mail address. There are numerous ways to gain access to the "net". If you subscribe to any of the major online information services, you have an Internet mail address.

Your address is your logon ID+ "@aol.com" for America Online, **"@compuserve.com"** for CompuServe, **"@eworld"** for eWorld user, etc. Telephone numbers and rate information for the major online service

providers are listed below for your convenience:

America Online: ... (800) 301-9966
The start-up kit includes 10 hours of free access
\$9.95/month (includes the first 5 hours of access) plus \$2.95/hour

CompuServe: (800) 881-8961
The start-up kit includes 10 hours of free access

Two monthly plans are offered:
1) \$9.95/month (includes the first 5 hours of access) plus \$2.95/hour
2) \$24.95/month (includes the first 20 hours of access) plus \$1.95/hour

Physician's Online: (914) 332-6100 or (800) 332-0009

America Online and CompuServe provide many consumer oriented services in addition to Internet access for e-mail and world wide web (WWW) access.

Physician's Online is a free information service, including Internet access for e-mail, that was created specifically for physicians.

Physicians' Online Overview:

Physicians' Online is the first and only national online medical information service to offer member physicians free, unlimited use of the most current and comprehensive medical information available.

Creators: Physicians' Online, Inc., a privately-held company located in Tarrytown, NY, launched the service in February 1994.

Philosophy: Created by physicians

for physicians, the company's goal is to advance the exchange of knowledge throughout the medical community and to help physicians respond effectively to patients' problems and concerns at the point of need — anytime, anywhere.

Core Services: Physicians' Online offers members access to core reference services, including:

- MEDLINE® - Compiled by the National Library of Medicine, MEDLINE offers seven million references from 3,700 international medical journals dating back to 1966. Updated weekly;
- AIDSLINE® - Compiled by the National Library of Medicine, AIDSLINE provides access to over 80,000 references about AIDS and related topics from 4,000 journals dating back to 1980. Updated monthly;
- CANCERLIT® - Produced by the National Cancer Institute in cooperation with the National Library of Medicine, CANCERLIT includes over one million references to journal articles, government and technical reports, meeting abstracts and papers on major cancer topics dating back to 1963. Updated monthly;
- HEALTH - Produced by the American Hospital Association in cooperation with the National Library of Medicine, HEALTH contains over 740,000 journal article references dating back to 1975 which cover the administration and planning of health care delivery. Updated monthly;

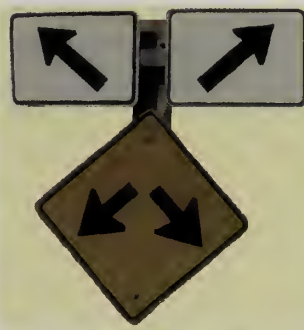
- **AIDSDRUGS/AIDSTRIALS** - AIDSDRUGS provides an online directory of chemical and biological agents currently under evaluation in AIDS clinical trials. AIDSTRIALS, its companion source, covers open and closed clinical trials related to the treatment of AIDS and related infections. Both are provided by the National Library of Medicine;
- **Drug Interactions** - Fast and easy access to the most up-to-date interactions for a single drug as well as for multiple drugs;
- **Clinical Alerts** - Prepared by the National Library of Medicine in cooperation with the National Institutes of Health, this service supplies findings from clinical trials prior to their publication;
- **Prescribing Decision Support Tools (PDST)** - PDST presents online information on specific drugs from pharmaceutical manufacturers and the FDA;
- **Query By Example (QBE)** - QBE provides for more specific searches in MEDLINE, AIDSLINE, CANCERLIT and HEALTH in two quick and easy steps. QBE takes a fingerprint of a selected reference and identifies additional relevant articles;
- **Medical Tribune News Stories** - Adds full-text medical news stories, published by the Medical Tribune News Service, to the resources available on Physicians' Online. All articles will be archived by subject for future reference.

Interactive Online Information Centers:

In addition to the core reference services, Physicians' Online has added interactive information centers to improve the quality of information exchange and retrieval.

- **Association Electronic Forums** - Allows national and state medical associations and societies to share information with their members online. Member physicians access newsletters and news published by their associations. Other features include: online bulletin boards, opinion polls, and specialized community forums;

- **Disease Centers** - Offers physicians the most up-to-date information on specific diseases through online forums and bulletin boards. Members can download or order tools such as patient education literature, health guideline descriptions, continuing medical education (CME), research studies and other supplies and materials;
- **Topical Forums** - Forums on such issues as H. pylori, AIDS and Health Care Reform;
- **Managed Care Centers** - Links managed care organizations and their member physicians to provide managed care physicians with instant access to such features as online versions of their MCOs' formularies, news bulletins, e-mail, surveys and much more.



Communication

Physicians' Online has added the following features to provide physicians with the opportunity to share personal experiences and ideas that are beneficial to their peers:

- **Global e-mail** - Enables member physicians to communicate with each other or connect to other online e-mail systems via the Internet;
- **Message Boards** - Facilitates communications between and among groups of health care physicians;
- **Online Surveys** - Encourages member physicians to express ideas and provide feedback on health care related issues and the many services available through Physicians' Online.

Premium Features:

While most of the services offered by Physicians' Online are of no cost to its member physicians, some premium features will be associated with a small fee. Members will have the choice of whether to use such features, and are not required to do so in order to access the free core services:

- **Full-text Professional Journals and Textbooks;**
- **CME** - Offers various online continuing medical education programs;
- **Additional patient education materials.**

Key Benefits:

Member physicians in the United States enjoy free, unlimited use of core reference services. The service is also:

- Fast and easy to use. It uses a unique natural language interface;
- Available in Window® and Macintosh® versions;
- Compatible with almost any computer with a modem.

Availability:

For further information, please call Physicians' Online Member Services at 800-332-0009. Software for Physicians' Online can also be downloaded from the service's home page on the World Wide Web at <http://www.po.com>. However, only physicians are able to access the service.

CMS Web Page

Our web page is currently under construction, and will be available in the near future.

CMS Staff Internet Directory

The staff Internet Directory is printed on the following page.

Colorado Medical Society Staff Internet Directory

CMS staff can be reached at the following internet addresses:

Executive Office

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Mary Lee Johnston, Executive Administrative Asst.
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Richard Allen, MD, Chairman
Council on Legislation

Another Annual Meeting of the CMS House of Delegates is behind us., New officers have been installed, new council and committee appointments have been made. This includes the Council on Legislation, which had its initial meeting on October 18. This year's council membership contains a mixture of veterans and new faces. The most active and regular attendees were reappointed. New appointees were carefully selected to provide a broad balance of opinions from different geographical and practice specialty areas.

These new members were brought up to speed on summer legislative activities and on plans for the new session. I wish to do the same for the CMS membership at large.

Licensing Issues

Sunset Review hearings in September and October produced a variety of recommendations from the Department of Regulatory Activities (DORA). These include evaluations of the scope of practice among the various groups licensed by DORA. CMS has been actively involved in some of these evaluations and recommendations. Others, CMS will monitor. For example, licensing of pharmacists under the Pharmacy Practice Act was reviewed. While CMS does support the continued licensing and regulation of pharmacists, the Legislative Council opposed expansion of their scope of practice to include initiating prescription of medications.

The Council also testified against the continued licensing of Direct Entry (Lay) Midwives, on the grounds that the State has not done an adequate job of monitoring their activities and regulating their practices. We also contend that giving credence to various alternative providers is not in the public's best interest.

The bad news is that the Sunset Committee accepted DORA's recommendation to continue the midwives' licensing; however, the good news is that their scope of practice was not expanded. We will be revisiting this matter when it is scheduled for hearing during the legislative session.

Rural Health

We have worked all summer drafting a rural health bill. This proposal is now ready to go, with sponsors lined up. The bill will contain incentives, such as loan repayments, to induce new physicians to set up practice in rural Colorado, and tax credits to encourage existing rural physicians to stay in practice. Obviously, there will be some fiscal impact for the state, so there may be some opposition to this bill. Our read from rural legislators is that they will be quite supportive of the measure.

Point of Service

You'll recall that last year we attempted to get a "point of service option" bill passed in the legislature, but received considerable opposition from the business community. We are going to try again in our efforts to improve access to our patients through what we're euphemistically calling "son of point of service". However, in order to forestall a repeat of last year's defeat, we have been meeting regularly with a group of employers to find acceptable language for our bill, without putting any burdens on them. We now believe we have a bill which does not mandate anything from business but, instead, places the onus on the insurance industry to make point of service options available for employers and their employees. We expect the initial draft to be ready in December as opinions and comments are still being gathered.

(Continued)

COPS Grows in Importance

Dr. Joel Karlin (CMS President) and I have reinstituted the Coalition of Physician Specialties (COPS) and we have expanded the group to include staff people so we can have a better continuity and follow-through from year to year. COPS serves as a sounding board for physicians to discuss mutual interests and problems, and to look toward legislative solutions which we can pursue collectively rather than separately. This group also helps keep open the lines of communication between components of

organized medicine. I cannot overestimate the importance of physicians working together.

Health Insurance Reform

Finally, the Governor has appointed a task force to investigate the problem of the growing number of uninsured and underinsured Coloradans, and how to provide these people with appropriate medical care. There is a presumption that the proposed \$270 billion in Medicare/Medicaid cuts will be approved after compromise, and that we are probably looking at block

grants for Medicaid. Colorado may lose federal Medicaid dollars and will need to have an alternate mechanism in place for providing the services. The problem is how to provide more government services with fewer government dollars.

We are just getting warmed up. As usual, it should be an interesting session. We invite all of you to participate. There will certainly be many times when we need your collective support. Feel free to contact the CMS Government Relations staff if you have questions.



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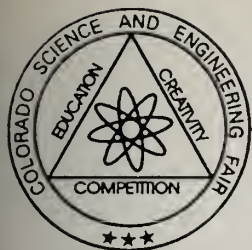
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Colorado Science and Engineering Fair

***** SCIENCE FAIR JUDGES NEEDED *****

If you are a scientist, engineer, physician, nurse, veterinarian, educator, psychologist or other professional practicing in the fields of science, medicine, mathematics, computer science or engineering, you are invited to participate as a Regular Awards Judge for the **1996 Colorado Science & Engineering Fair (CSEF)** which will be held at Colorado State University in Fort Collins, on April 11-13, 1996. Judging will be Thursday, April 11th from 11 am to 5:45 pm. **Team Captains and Assistant Captains must arrive at 10:30 am for a briefing meeting. Team Captains will serve on the All Fair Judging Team and be required to stay until 7 pm.** A more detailed judging schedule will be provided in March 1996 for those who will judge. Judging category descriptions are listed on the back of this letter. If you are willing to be a judge, complete and return the Judge Information Card (bottom of this letter) by February 16, 1996. If you know someone who would like to judge, give them a photocopy of this letter.

Also, to assure a fair judging environment and avoid any possible conflict of interest, perceived or actual, we request that anyone involved in any capacity with a Regional Fair associated with CSEF (i.e., a Sponsor/Teacher/Relative of student(s) exhibiting at the CSEF) describe your involvement in the space provided on the Judge's Information Card. The Regular Awards Judging Committee Chairperson will decide your eligibility to judge based on this information and that decision will be **FINAL**. Regional Fair Directors, Co-Directors, and Assistant Directors are **NOT** eligible to judge.

Acknowledgement of receipt of your Judge's Information Card will not be sent to you. **Please assume that if you send a card volunteering to judge, you will be judging on Thursday, unless otherwise notified.** Volunteers will be contacted by phone to confirm special assignments, such as Team Captain assignments. **Judging team assignments and information packets will be sent to all judges in March.** If you do not receive a Judges Information packet by March 27th, please contact Gina Holland. Thank you for your support of the 1996 Colorado Science & Engineering Fair.

RETURN JUDGE'S INFORMATION CARD (bottom portion of this letter) TO:

CSEF Regular Fair Awards Judging Committee

Gina Holland - Chairperson

2669 S Howell St

Lakewood CO 80228

303/329-1720 (w)

303/987-0377 (h)

.....DETACH HERE AND KEEP TOP PORTION FOR YOUR RECORDS.....

COLORADO SCIENCE & ENGINEERING FAIR

1996

Check all that apply:

- ☐ YES, I will be able to serve as a **JUDGE** on **Thursday, April 11, 1996**, at Colorado State University.
- ☐ YES, I am willing to serve as a **CAPTAIN** or **ASSISTANT CAPTAIN** of a Judging Team.
- ☐ YES, I am interested in **CARPPOOLING** with other judges from my area to CSU (Fort Collins).
- ☐ I will **NOT** be able to serve as a **JUDGE** in **1996**, but **KEEP** my name on the **MAILING LIST** for **1997**.
- ☐ **REMOVE** my name from the **JUDGES' MAILING LIST**.

Are you involved in any **REGIONAL FAIR** associated with the Colorado Science and Engineering Fair? ☐ **NO** ☐ **YES**, in the following capacity--
Sponsor ☐ Teacher ☐ Relative of Student(s) in Grade(s) _____, CSEF Division(s) _____, Category(ies) _____

Other Regional Fair Involvement: _____

Indicate your preference (1,2,3) for the **CATEGORIES** of expertise you'd be willing to judge:

_____ Botany _____ Engineering _____ Health & Behavioral Sciences _____ Physical Sciences
_____ Mathematics & Computer Sciences _____ Earth & Environmental Sciences _____ Zoology _____ Teams

Indicate your preference for **DIVISION**: ☐ Junior Division (Grades 7-9) ☐ Senior Division (Grades 9-12)

Name: _____
Home Degree(S)/Subject(S): _____
Mailing Address: _____
State: _____ ZIP: _____
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Job Title: _____
Employer: _____
Supervisor's/Manager's Name: _____
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PLEASE RETURN BY FEBRUARY 16, 1996 • ANY QUESTIONS? CONTACT GINA HOLLAND 303/329-1720

1996 COLORADO SCIENCE & ENGINEERING FAIR JUDGING CATEGORIES

BOTANY: Subjects such as plants, (bacteria, fungi, mosses, ferns, seed plants), plant ecology, plant pathology, agriculture, conservation, forestry, evolution, genetics, plant growth, paleobotany.

EARTH & ENVIRONMENTAL SCIENCES: Projects illustrating principles of geology, geography, and related fields.

ENGINEERING: Applications of science directed toward the development of devices, structures, technical procedures, etc., which are useful to humankind; such devices are electrical, civil, mechanical, chemical, aeronautical, geological, and other similar fields of technical work.

HEALTH & BEHAVIORAL SCIENCES: Projects with the primary emphasis on human health and behavior.

MATHEMATICS & COMPUTER SCIENCE: Projects whose main emphasis is on the illustration of theories and principles of any branch of mathematics, or demonstrating new developments in computer software, computer systems organization or methodologies.

PHYSICAL SCIENCES: Projects illustrating principles of physics, chemistry, astronomy, and related fields.

ZOOLOGY: Subjects such as animals, protozoa, and other invertebrates, vertebrates such as birds, fish, amphibians, reptiles, humans, paleontology, evolution, animal husbandry, conservation, genetics, animal growth, animal behavior (psychology).

TEAM PROJECTS: Teams have a maximum of 3 students and enter projects from any of the above categories. Since the judging must be interdisciplinary, judges will be required to have judged at CSEF at least once within the past 4 years and previous All Fair judging experience is preferred. The top Senior Division Team wins a trip to the 1996 International Fair.

ALL FAIR: The Captains of each of the categories (except TEAMS) form a team to choose the top three exhibits in each division.

From:

Colorado Science & Engineering Fair
Regular Awards Judging Committee
c/o Gina Holland, Chairperson
2669 S Howell St
Lakewood CO 80228

FROM:

FILE
CLERK
LETTER
POSTAGE
REQUIR

**TO: Gina Holland
2669 S Howell St
Lakewood CO 80228**



John L. Lightburn, MD
Historian, Colorado Medical Society

Colorado's only physician ever to become President of the American Medical Association.



Hubert Work, M. D.
Pueblo, Colorado
1860 - 1942

Truly a giant of a man and a physician, Dr. Hubert Work was the 25th President of Colorado Medical Society.

As many of the CMS pioneers were, Dr. Work was a remarkable individual for his medical and psychiatric skills as well as his political and administrative abilities.

He was Postmaster General of the United States in the Cabinet of President Warren G. Harding, and Secretary of the Interior in the Cabinets of Presidents Harding and Calvin Coolidge. He first established his medical practice in Greeley, Colorado, then later moved to Pueblo. There, in 1896 he founded the Woodcraft Hospital for Mental and Nervous Disease. He became chairman of the Colorado State Republican Committee, then went on to become Colorado's National Committeeman from 1913 to 1919. In 1920, Dr. Work was elected the President of the American Medical Association, the only Colorado physician ever elected to that post.

Dr. Work was present with President Harding on his trip to Alaska during the summer of 1923 and was one of the attending physicians at his last illness. Dr. Work resigned as Secretary of the Interior in 1928, but he continued his efforts in Colorado with the GOP.

Dr. Work served as a member of the Colorado State Board of Medical Examiners, was president of the state Board of Health for four years. In 1917, Dr. Work volunteered for the United States Army, rising to the rank of Colonel by the end of the war. He was cited for distinguished services, acting as medical adviser to the



Col. Hubert Work, MD
U. S. Army Medical Service
1917-1919

Provost Marshal General's Office.

In addition to his stature as a giant in offices of national and international government, the scientific and the organizational halls of medicine, he was a gentle, caring individual. His 1942 obituary read,

"Dr. Hubert Work was a kindly man, endearing himself to everyone by his affability, calm and reserve. He inspired cooperation and efficiency and was ever ready for usefulness with kind comment and witty repartee."

Dr. Work is buried in Arlington National Cemetery.

Following are excerpts from Dr. Work's 1895 CMS House of Delegates closing speech, in which he clearly identifies some of the accomplishments, the challenges and the pitfalls facing medical practitioners today. Dr. Work's address has inspiration, a beauty and a flow neither worn nor eroded by time.

*John L. Lightburn, MD, was elected as Colorado Medical Society Historian at the Annual Meeting in Aspen, September, 1995. He is a Denver native, has been in practice in Denver since 1955 and a member of CMS for 37 years. Dr. Lightburn is retired.

100

years ago - 1895

Proceedings of the Annual Meeting
Colorado State Medical Society
President's address

Hubert Work, MD
President, 1894-1895
Colorado Medical Society



"Members of the Colorado State Medical Society, we are about to close our Twenty-fifth Annual Convention.

The work of this session represents the medical achievements of a quarter-century in a new State, and it should be a source of mutual congratulation that the papers discussed have been as professional and scientific as those read before similar societies whose membership is derived from a country tributary to the old medical centers of the Eastern States.

Only those of you who have been members of this society since its birth or who have had access to its early "Transactions," are able to appreciate its progress as a medical organization.

The characteristics of the different papers read at its annual meetings clearly disclose the advancing steps of medicine during the period covered.

This session, completing as it does our first twenty-five years of organized existence, you will be willing to retrospect a little. After all, the history of that which has been accomplished is but a history of men.

Of the sixteen physicians who in 1871 signed the resolution creating a Territorial Medical Society, broke the ground and laid the cornerstone of our present organization, but five are at present on our rolls of membership. Some have passed over the mountain range to western fields, and some have crossed the border of the undiscovered country. The much-loved Steele, announcement of whose going personally

bereaved his every acquaintance; McMurtrie, the studious son of a distinguished father; Buckingham, to whom fell the honor of being your first presiding officer; Thacker, whose failing health compelled his resignation from that office; Williams, a man for whom the poor wept when he died, and the immortal Davis, whose strong heart did not decline with years, but rode it out with him through life and death. These, our one time Presidents, we no longer see. As they preceded us in this medical field, they have gone on before in the journey to the mystic plains of the hereafter.

Displeasing as personal mention is to the worthy living, I cannot but express the Society's respect for those charter members who still meet with us. Bancroft, Stedman, McClelland, Elsner and Edmundson alone remain to represent the founders of Colorado's Medical Society.

For a quarter-century these men have kept abreast, often in advance, of the strides of medicine, until they stand today as easily our fathers in the profession as they are in years.

Each name a tower of strength, in medicine, in the community and in the State. Let no one of our members, youthfully self-confident, disparage the Colorado physician of twenty-five years ago. "There were giants in those days, and their good works live after them."

During its second decade and a half the Society was represented through its Presidents by the scholarly Anderson, of Southern birth; the gifted Thombs, for half a generation the trusted custodian of the state's insane, and whose military record is written history; the brilliant Lemen, and the versatile Hawes, a boy soldier, then a medical student, and ever since a student of Medicine; by Fisk and Solly,

whose studies on phthisis have won for them international reputation; and by Graham, Wilson, Collins and Rogers, the selection of whom was less an honor conferred than a dignity received; and by Eskridge, that distinguished master of mental intricacies; and by Strickler, for whom life's evening shadows have been prematurely lengthened, and his journey down the western slope darkened, suggesting this paraphrase of the divine apostrophe: "Greater devotion hath no man than this, that he imperil his life for the suffering."

With mental portraits of such men as those hung in the galleries of memory, the present advancement of our organization is explained, and a stimulus provided for future achievements.

Revolution of Medical Science

Since this Society held its first meeting, its members have seen the revolution of medical science. It has been divided and sub-divided into many branches and specialties. Doubtless that branch which contemplates the treatment of the diseases to which women only are subject, has made the most rapid advancement. But seven American colleges had at that time established chairs for the exclusive teaching of this branch and it is less than twenty years since the American Gynecological Society was organized, the reports of which constitute a history of medical and surgical progress greater than ever before published.

Relief of Afflicted Women. . . the name of Sims made immortal. . .

The surgical procedures now so common for the relief of afflicted women have mostly been devised and perfected in technique since then, and

the names of those pioneer teachers are now everywhere revered. While that great teacher of the wise, the godfather of gynecology, whose very memory is a legacy—trustful as a child and gentle as a mother—has also passed for the last time from the amphitheater, leaving behind him a record of good works, and the name of Sims made immortal. It is no longer necessary that the sensitive woman be distressed by necessary treatment from those of the opposite sex, for with the development of her necessities came her educated sister, by whom the timid wife may be counseled when the fears of approaching maternity weigh upon her; and under whose guidance the school-girl's strength may be conserved, and that instinctive delicacy, the chief charm of young womanhood, remain unblushing.

It can be said of general surgery that it has kept equal pace, since operative gynecology is but a branch of it. It has successfully invaded the brain and spinal cord, resected the spinal column, recognized and removed the suppurating appendix, seeks to relieve the compressed brain of the congenital defective, enables the rachitic mother to bear living children, and educates aright the spinal column of the incipient hunchback.

It is the pride of this Association that its membership embraces those who successfully execute all the advanced surgical procedures known to any country, many of which at the time this Society was conceived were believed impossible.

The advancement in therapeutics has been a matter of experience, rather than a subject of history, with those of our charter members present. Progress in this branch has been accomplished by winnowing from the yearly harvest of new remedies sought to be introduced the few grains of value, rather than a supplanting of the tried and proven; and by the careful search for the smallest possible dose, and the most elegant excipient.

The practical results are most encouraging. The mortalities of epidemics grow progressively lighter; the feeble newborn now lives that a few years ago must have perished, and the average length of life is increasing.

“...the era of preventive medicine well advanced. . .”

We find on our twenty-fifth anniversary the era of preventive medicine well advanced, and all indications bear evidence of rapid increase in scientific attainments among medical men. It is reasonable to predict, from the recent history of medicine, that we are now on the verge of greater advances in knowledge of remedial and preventive agents than ever before, because of the spirit of investigation that is abroad in the land. The recent discovery of an anti-diphtheritic, with whatever of value time may vouchsafe it, together with others of like nature, are but earnest of latent probabilities in medicine.

The elements of great successes are visible in the wrecks of great failures, and the direct outgrowth of the impetus given to experimental investigation by the announcement of Koch's tuberculin is seen in the advent of the anti-toxins, but one of the many discoveries we will probably see, the inception of which had like origin.

“...those who restrict practice to a few organs, necessarily narrows the scope of vision. . .”

Apparently, that which most threatens continuous medical advancement, is the tendency to elaborate refinements of specialism.

It is argued, and with reason, that one mind cannot comprehend all the branches of medicine or surgery, much less acquire the manual dexterity requisite for the skilful execution of the varied operations. It is true that the field of medicine has become so broad and its practice so scientific that those who devote equal attention to all its branches can hope to contribute but little to what is already known.

But we are all made to realize the involuntary tendency of the skilled gynecologist to remove the ovaries for hysteria, and of the honest oculist to fit glasses to all children with headache. And it has not been long since a good man announced the sole cause of epilepsy to be that of nasal irritation.

These sometime errors are by no means unpardonable, but indicate that the limited field of observation open to those who restrict practice to a few organs, necessarily narrows the scope of vision to a degree impossible to sur-

mount, if adopted as the initial step of practice.

Delicacy of the tactile sense must of necessity be preserved, and operative skill comes only through constant repetition; but the study of diseased action, if not its treatment, must be comprehensive, or a reputation of operative skill only, will depreciate the value of services rendered to the profession by those to whom we are already indebted for so much of value.

The specialist in medicine should be the result of general practice, not a part of it; the product of experience, and not created through the process of exclusion; for no organ can be successfully treated without a due appreciation of its associates and their relations.

It will always be true that each practitioner will develop a particular aptitude for special lines of work, and it should be encouraged; but the prevalent tendency of students to enter college with avowed intention of being graduated into specialists, there is a growing menace to the symmetrical development of medical science”.

Closing:

“Ladies and gentlemen, the office with which you one year ago entrusted me, I now return to you; and in so doing, I wish to assure you of my high appreciation. No one can be the President of this association of medical men and women, without being keenly sensible of his own imperfections, and without realizing that he occupies the position of greatest honor within the gift of his fellow physicians.

For the active and intelligent co-operation of your committees, and for your cheerful assistance and kindly forbearance, I thank you.”

Ed. Note: The Denver Medical Library Foundation, celebrating its 100th birthday in 1995, is the “executor” of some of Dr. Hubert Work's lasting contributions to medical practice in Colorado. He left the library a \$50,000.00 endowment which, to this day, remains on deposit. The earnings from this endowment have funded purchase of scientific books in the fields of neurology, neurosurgery and psychiatry. These valuable additions over the years have helped make the Denver Medical Library a widely acclaimed scientific collection.

P rogress Report



Leigh Truitt, M.D.
Leigh Truitt Consulting, Inc.

As most of you know, I have been working with the Colorado Medical Society and the Colorado HMO Association since May, 1995, to help physicians in their business relations with managed care organizations. This was funded by Resolution-61-A from the Annual Meeting of the CMS in September, 1994, as follows:

RESOLVED, the Colorado Medical Society shall insure that, pending favorable negotiated agreements of cooperation with the Colorado HMO Association, appropriate funding will be made available to employ a physician. This physician will interface with health plans doing business in Colorado to implement affiliation/disaffiliation criteria and will strive to see that reporting of physician economic and quality performance is unambiguously presented in the form of a report card. This physician will assist member physicians in understanding the information provided them, including insight on how the report card results may be improved.

and further defined by the White Paper on Physician Affiliation/Disaffiliation of January, 1995.

During the past summer, I surveyed six HMOs to learn more about their practices and policies for selection, credentialing, practice analysis, recredentialing, and termination of their physician panels. The results of that survey were presented to the Annual Meeting of the CMS in September. Copies of the survey can be obtained from the Medical Society.

At present, I am beginning a project with a Subcommittee of the Data Committee of the CMS, with additional participation of representatives of the CO HMO Association,

to study in depth the analysis of physician practices by HMOs. An initial survey of all the HMOs in Colorado will be used to determine the key performance measures (KPMs) used by these organizations to profile physicians.

These will include such financial measures as per member per month charges as well as referral, laboratory, prescription drug, and emergency room costs for primary care physicians. For specialists, we anticipate looking at physician charges per event (per referral, procedure, intervention, etc.) as well as the associated costs such as hospital and ancillary charges. We will be attempting to learn more about assignment of responsibility when multiple physicians are involved, definition of the scope and duration of an event, numbers of patients or events necessary to determine statistical significance, profiling of distribution of codes, etc.

In addition, there are other KPMs more related to quality of care such as mammography, diabetic retinopathy, cholesterol screening; use of angiotensin converting enzyme inhibitors in congestive heart failure, aspirin in myocardial infarction; as well as rates of cesarean section, immunization, low birth weight, etc. Increasingly, physicians will be tracking these and similar measures on their own so that they can improve their performance before the plans point out their deficiencies.

Our hope is to be able to obtain some consistency of definitions, standards and reporting of this type of data. Once we learn more about

"Our hope is to be able to obtain some consistency of definitions, standards and reporting of this type of data."

this, I will be preparing an educational presentation for physicians so that information can be more readily communicated from the managed care organizations to physicians in a timely and useful manner. In our opinion, this will be of benefit both to the organizations and their individual physicians.

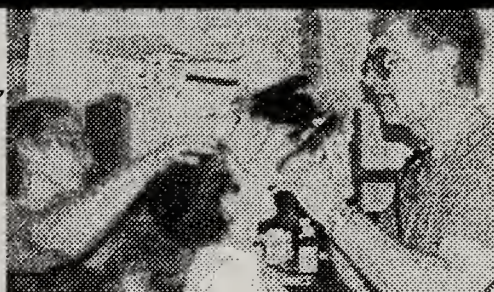
I also intend to prepare a guide for physicians that will describe resources to assist them in evaluating and improving their practices so that they may maintain their membership on managed care panels. This will include short descriptions of the functions of organizations such as the Colorado Physicians Health Plan, the Colorado Personalized Education Program for Physicians, the Colorado Foundation for Medical Care, and others, as well as additional resources for legal advice, practice management, career counseling, etc.

I have also been available to counsel physicians who have been terminated from managed care plans. This usually involves finding out the circumstances of termination from the medical directors of these plans as well as determining if there are any possibilities of obtaining reinstatement through joining another group such as an IPA or physician hospital organization. If the termination is for quality reasons, I can suggest means for practice evaluation by an independent agency or possibly reeducation or retraining. If the termination is for excessive utilization, I can evaluate the process to determine if it is accurate and statistically significant if the managed care organization

will permit. I anticipate that more and more physicians will find their opportunities to participate in managed care panels will be curtailed because of the trends toward tighter integration and more aggregation of physician groups, hospitals and HMOs. We all need to be looking to our future and planning realistically. I am available as a service of the CMS to assist physicians who need help in their relationships with managed care organizations and can be reached at (303) 321-2598.

"I am available as a service of the CMS to assist physicians who need help in their relationships with managed care organizations and can be reached at 303-321-2598."

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LT John Clifford
(303) 367-4397

Bonfils Builds New HQ at Lowry



Bonfils Blood Center has begun moving into their new headquarters building at the former Lowry Air Force Base. The federal government provided the former commissary building to the blood center, a 13 acre tract of land with building valued at more

than \$10 million. Bonfils will spend about \$8 million to reconstruct the building.

Improvements made possible by the 150,000 sq. ft. center include 23,750 square feet of laboratory space, a community donor center, which will be the only one to accommodate whole blood, platelet and plasma donations in the same location, a library, conference center, education center, auditorium and warehouse space to be shared with other organizations. Bonfils plans to raise the \$8 million by selling their lease to the 9th and Colorado Building (they will still maintain a blood donation center there), liquidating investments, borrowing some money and garnering \$1.5 million in charitable contributions.

Colorado's physicians have long supported the volunteer blood donation efforts of the Bonfils Blood Center. Dr. Osgoode S. Philpott, Sr. donated the first unit of blood when the center first opened in 1943. Dr. Philpott, who was instrumental in upholding the society and public

health interests during World War II, would have been 100 years old this year and certainly proud to see the progress made in the cause of volunteer blood donation and research in the Rocky Mountain region which is represented by the construction of this new state-of-the-art center.

CMS member Ben Galloway, MD, who chairs the Bonfils Blood Center Foundation board of trustees, says, "The move to Lowry will help Bonfils improve our custodianship of the blood supply — that will benefit everyone in this community."

In most parts of the country, blood donation is handled by the American Red Cross. In Colorado, the Bonfils Blood Center provides more than 100,000 units of blood and blood products to patients in 89 hospitals and healthcare facilities throughout the state. In addition to the main center, Bonfils maintains eight community donor centers and conducts 1,000 mobile blood drives each year. They also administer the Colorado Marrow Donor Program.

Bonfils depends totally on volunteers for the donation of lifesaving blood. 97% of Coloradans will need blood or blood products by the time they reach age 72, however, only 4% of the population donates.

Bonfils Blood Center is the first technology-based organization to relocate to Lowry. In the past ten years, the Center's volume of work has more than doubled and they have had to lease facilities eight miles from their main building to house 40 percent of the operating and support programs.



Medical assistants are the most versatile healthcare worker in the field today. Medical assistants are employed in a variety of health care related fields in physicians offices, clinics, hospitals, pharmacies and nursing homes. We perform both clinical and administrative duties. We serve as your first contact for patients as well as the staff member to whom many patients communicate most freely. We are the staff member on whom the physicians rely to help direct the patient's understanding of both their treatment and the ever frustrating insurance coverage.

Colorado Society of Medical Assistants is the professional organization that promotes continuing education and networking in the field of medical assisting. CSMA attempts to meet the needs of the physicians and employers by providing quality continuing education seminars on a regular basis to

keep staff members informed of the constant changes in the health care field.

The members of the Colorado Society are your staff members who are dedicated to continuing their education to be the "most versatile" employee for the betterment of your practice and your patients.

Colorado Society's next continuing education session will be Saturday, January 27, 1996 at Lutheran Hospital. Topics covered will be medical ethics and cardiac intervention/cardiac rehab. Continuing education credits will be available for those participants needing continuing education credits... Educational seminars are open to all medical assistants and others interested in attending.

For additional information about Colorado Society membership please contact Lin Fabrizio at 425-4197, Boni Bruntz CMA-A 343-0163 or Marsha Broste CMA-C 756-9522.

by Boni Bruntz, CMA-A



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In 1990, the Colorado Legislature created the Colorado Uninsurable Health Insurance Plan (CUHIP). CUHIP provides health insurance for those who cannot obtain it through regular carriers. In 1994, it was expanded to include all eligible employees in groups of 2-50 and in 1996, it will apply to self-employed persons as well.

CUHIP estimates that thirty to forty percent of Colorado's employers do not offer their employees health insurance. The program is designed to provide affordable health insurance for those employees as well as temporary or part-time employees who do not qualify for their employer's plan, retired persons not yet eligible for Medicare and some divorced or widowed persons. Premiums are generally 150% of those charged by the state's largest insurers and are based on age, gender, county of residence and whether or not the participant smokes, as well as on the deductible choice (Participants can choose either \$300, \$750 or \$2,000 deductible). Monthly premiums would range from a high of \$590.47 for a 64-year-old Denver man who smokes to a low of \$56.70 for a 14-year-old girl living in Fremont County. The average in 1994 was \$233.

In order to be eligible for CUHIP, a person must be a U.S.

Citizen or legal alien, a Colorado resident for at least six months and meet one of several conditions. A person may be eligible if that person's application has been rejected because of present health or previous medical condition; if the application has been accepted with exclusion of coverage for a preexisting condition for more than six months; if the application is accepted but the premium rate is higher than CUHIP's or if the person's health insurance coverage has been involuntarily terminated for a reason other than nonpayment of premiums.

Though CUHIP loudly touts its acceptance of those with preexisting medical conditions, there is a six month waiting period before coverage of a preexisting condition can begin. CUHIP says this is shorter than many private insurers. In addition, there is an option offering waiver of the waiting period for persons who have qualifying previous coverage which was terminated no more than 90 days prior to CUHIP coverage.

CUHIP is making a big push this year to get out the word among those eligible for the program. If you have any patients who may fit that category, please have them call 1-800-67CUHIP (672-8447) or 303-863-1960 or do it on their behalf.

We need your input

Managed care is clearly one of the biggest issues facing physicians today. The Colorado Medical Society wants very much to assist physicians in the managed care arena, but in order to do that most effectively we need your input. Following is a description of potential products and services we are considering offering to our members. On the reverse side of this page is a summary of CMS current managed care activities. Please take a moment to read this information and then complete the attached card and drop it in the mail to us so we can hear what you think.

Potential Products and Services

CMS is considering offering the following products and services:

1) Contract Review Service

CMS is considering negotiating a discounted rate for its members with one or more law firms to provide a contract review service.

2) Physician's Managed Care Manual

Topics discussed would include: financial incentives, insolvent plans, contract amendment negotiation, risk-sharing arrangements, capitation issues for specialists, verification of coverage, what to do when necessary care is denied, point-of-service plans, termination without cause and more...

What you should know about a plan before signing

How can you determine whether a capitated payment will be adequate?

Will your risk-sharing arrangement put you at too much risk?

3) Model Managed Care Contract

What language should go into your managed care contract? Is a health plan's contract problematic? This model contract would provide you with a "standard" to which you could compare a contract you are considering signing. Topics covered include: capitation provisions, termination provisions, fee for service provisions, risk withhold provisions, and hold harmless clauses.

4) Manuals on physician employment contracts and hospital-based physician contracts

For Current CMS managed care activities see reverse side.

Please complete the following information and mail this card back to us

How likely would you be to use the following products and services described above? Please circle one.

- 1) A contract review service provided by a CMS endorsed law firm for a reasonable fee (negotiated rate for CMS members)?

Not Likely

Somewhat Likely

Very Likely

- 2) A Physician's Managed Care Manual purchased for a reasonable cost?

Not Likely

Somewhat Likely

Very Likely

- 3) A Managed Care Model Contract purchased for a reasonable cost?

Not Likely

Somewhat Likely

Very Likely

- 4) Manual on physician employment contracts purchased for a reasonable cost?

Not Likely

Somewhat Likely

Very Likely

- 5) Manual on hospital-based physician contracts purchased for a reasonable cost?

Not Likely

Somewhat Likely

Very Likely

- 6) Comments: _____

Please identify the following:

Your Specialty: _____

City in which you practice _____

Current CMS Activities

For the past couple of years CMS has been working closely with the Colorado HMO Association (CHMOA). The first project was the **White Paper on Physician Affiliation and Disaffiliation** which was successfully completed a year ago. The White Paper was a collaborative effort between the organizations to inject fairness into the process of HMO affiliation and disaffiliation decisions. The White Paper is currently being implemented by a number of Colorado HMOs.

Since completion of the White Paper, representatives of CMS and the CHMOA have continued to meet and the group has become known as the **CMS/CHMOA Joint Committee**. The committee's mission is to enhance communication between Colorado HMOs and CMS. It shall also be used as a forum to discuss issues of mutual concern, to improve communication between Colorado HMOs and CMS, to increase collaborative efforts between the organizations and to facilitate implementation of the White Paper on Physician Affiliation and Disaffiliation.

CMS also has created a **Managed Care Task Force**. The charge of the task force is to 1) review issues and concerns of CMS members regarding managed care; 2) initiate topics it deems appropriate to be referred to the CMS/CHMOA Joint Committee for consideration and act as a resource for the Joint Committee if requested; and 3) make recommendations to the CMS Health Affairs Council and Board of Directors to modify CMS Managed Care policy as needed.

Finally, CMS was responsible for the creation of the **Colorado Physician Network (CPN)**. The partnership between CPN and Rocky Mountain HMO, which is currently under development, is intended to be a physician and patient friendly health plan available throughout Colorado.



Managed Care Survey
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by Ellen Stein, Director
Division of Health Care Policy
Colorado Medical Society

Standard Formats Required for Medicare Electronic Claims Submission

HCFA has issued a mandate requiring that only electronic claims submitted in either the ANSI 837 or the Medicare National Standard Format be accepted by carriers. Consequently, Medicare Part B carriers will no longer utilize or support any local formats. This means that Colorado physicians using BCBSC local formats (i.e., 80-byte and 160-byte formats) will be required to convert to Medicare National Standard Format or ANSI standards for submission of Medicare Part B claims to North Dakota.

If you have not already completed this conversion process, you must begin testing with BCBSND immediately. The first step is to complete an EDI Enrollment form. One danger in waiting until the last minute to complete the transmission process is that the carrier could be inundated with large numbers of physicians all wanting to do their testing at the same time right before the December 31 deadline. The carrier may not be able to accommodate these large numbers. *If you are unable to complete the process prior to January 1, 1996, it will be necessary for you to revert back to hard copy claim submission. The drawback to this is that paper claims are paid in 28 days, whereas electronic claims are paid in 15 days. There will be no extensions or exceptions to the December 31 deadline.*

Medicare Part B strongly encourages physicians to notify their vendors of the importance in establishing a schedule for testing and transmission. Physicians should be asking their vendors the primary question, "When will you be able to accomplish this task?"

As part of the conversion process, you will be required to submit at least one test file. This process is necessary to ensure compliance with National Standard Format or ANSI format structure and Medicare Part B billing

requirements.

Following are the steps you should follow to ensure a smooth electronic data interchange (EDI) conversion:

- If you have not received the EDI Conversion Packet that was sent in January or the December 1994 EDI News Flash, call EDI Support Services to request copies at 1-800-279-2547.
- Confirm with your vendor which formats you are using for electronic claim submission to BCBSC: BCBSC 80-byte format, BCBSC 160-byte format, National Standard Format, or ANSI Format. If you have a vendor who is responsible for your electronic claim submission process with BCBSC, contact them immediately to begin testing for you as soon as possible.
- If you are using BCBSC local formats for the submission of Medicare Part B claims, contact your programming staff or vendor. To continue electronic claim submission, you will need to convert to the National Standard Format or ANSI.
- If you are using National Standard Format or ANSI, you will need to make arrangements to create and submit your first test file. If you have a vendor, it will be very important to supply them with accurate claim data to ensure an accurate test. Providers will not be approved for EDI production status with BCBSND if test files contain errors in claim data.

EDI Support Services will work closely with you and your vendor as you make your electronic transition to your new Medicare Part B carrier. They also have an electronic billing software available to all Medicare Part B physicians free of charge. Call them at 1-800-279-2547 if you have any questions.

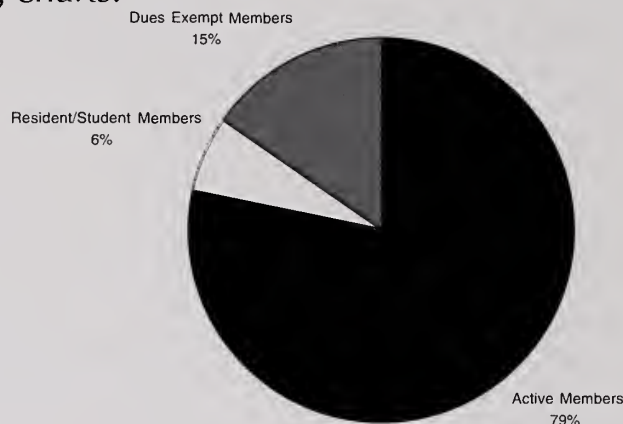
Effective January 1, 1996, all Colorado providers who submit electronic claims to Medicare Part B must transmit them directly to Blue Cross Blue Shield of NORTH DAKOTA (BCBSND). *As of this date, Blue Cross Blue Shield of COLORADO (BCBSC) will no longer take Medicare Part B claims and any such claims submitted to them WILL NOT be forwarded to BCBSND.*



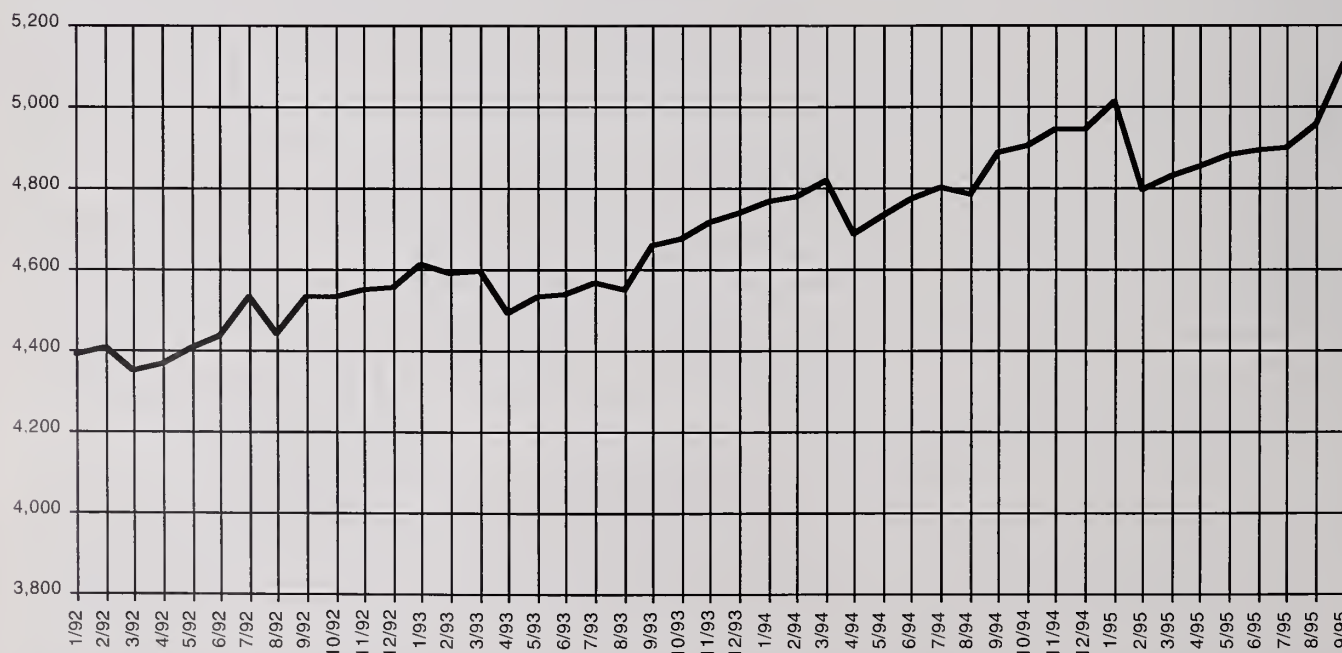
Membership continues to show a general upward trend, as shown in the accompanying charts.

Membership on the rise

Timothy Roberts, Director of Membership Information, reports that total membership topped 5,100 in October for the first time in the 125 year history of the Colorado Medical Society. Active members make up the heart of the society, and they total more than 4,000. It's also interesting to note that the future of the society also looks rosy, with residents and students forming an increasing portion of the membership.

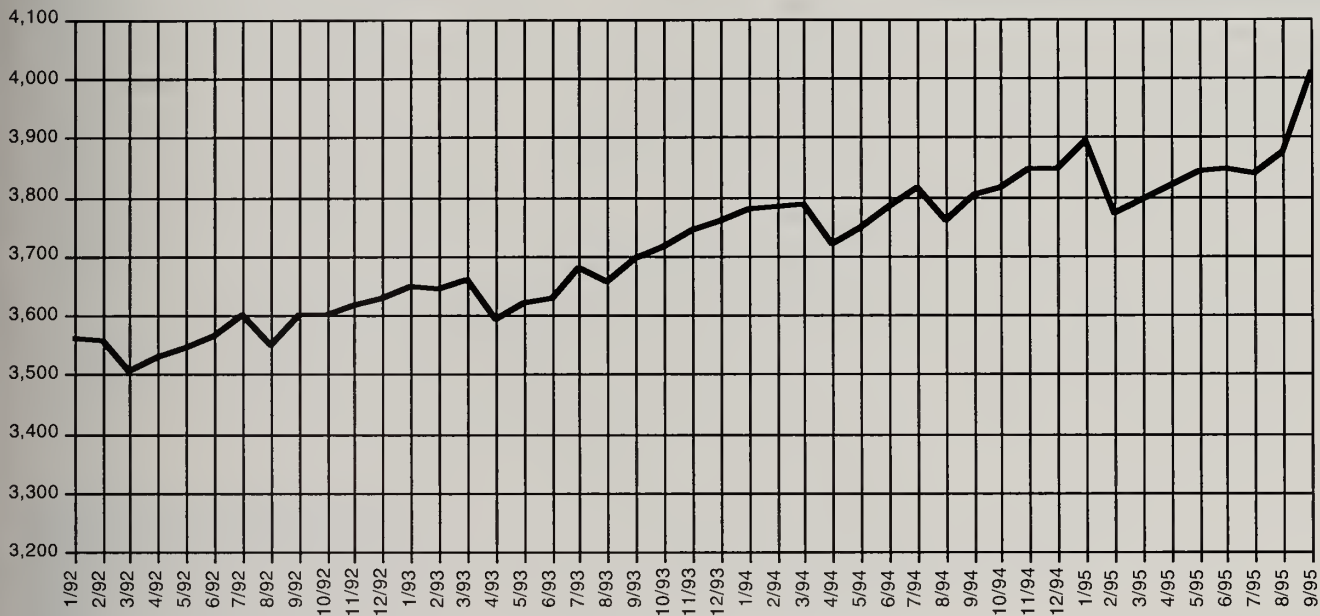


All Members

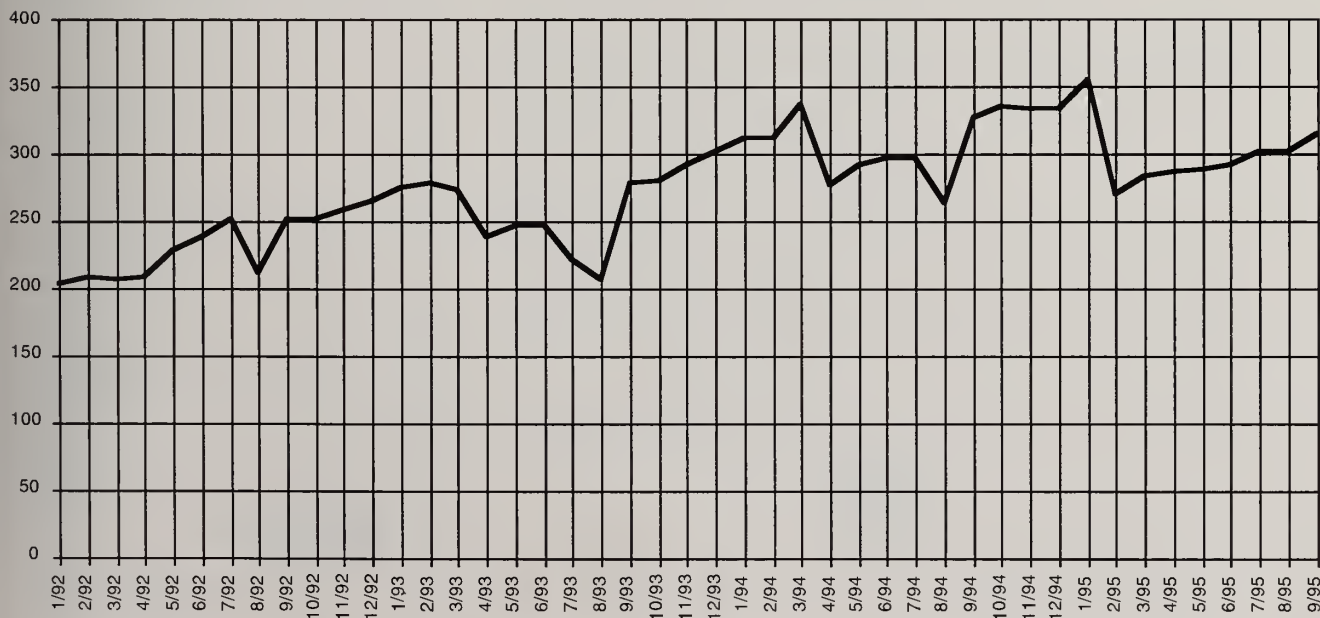




Active Members



Residents and Students



Non-Prescription Drug Handbook

*From our Internet
Discussion Group Sources*

INCAD and the American Pharmaceutical Association announce lower price for APhA Handbook of Nonprescription Drugs - now in Electronic Library.

The Handbook of Nonprescription Drugs, published by the American Pharmaceutical Association, provides the definitive source of information on over-the-counter (OTC) medications for the pharmaceutical industry. APhA and INCAD, inc. have agreed to make the full text of the new 10th edition of the Handbook available in electronic format. This edition of the Handbook provides pharmacists with all the data needed to counsel their patients on OTCs, including up-to-date information on Rx to OTC switches, changes in formulations and treatments, and conditions that can now be successfully treated with OTCs. APhA Member price is now \$150.

The 10th edition of the Handbook has been revised to:

- save time in referencing OTC products, with 37 chapters and 62 product tables
- inform pharmacists of the recent FDA final rulings regarding the safety and efficacy of OTC ingredients

- provide information on products that are sucrose free, gluten free, alcohol free, etc.

The electronic edition of the Handbook employs the powerful FolioViews retrieval software, and will include the drug tables as well as the full text descriptors, all searchable by word, phrase, or field with Boolean and proximity searches.

The APhA Handbook will be made available as an Independent CD-ROM publication, or within the context of INCAD's full Pharmaceutical Information Library (PhIL), a comprehensive suite of database products which includes complete regulatory, government documents and reference tools for Rx, OTC and Biologics information, on CD-ROM, online, and BBS environments.

The American Pharmaceutical Association represents the third largest health profession composed of more than 170,000 pharmacy practitioners, pharmaceutical scientists, and pharmacy students. Since its founding in 1852, APhA has been a leader in the professional and scientific advancement of pharmacy and in safeguarding the well-being of the individual patient.

For additional information, please contact INCAD at 703 7422-9419, or fax request for information to 410 740-1388. You can also e-mail Susan Severtson at severt@incadinc.com.

New Changes in Incident Reporting Announced

The Colorado Department of Public Health and Environment, Health Facilities Division, is changing its incident reporting policies and procedures. The changes were recommended by a 23 member task force co-chaired by Acting Executive Director Patti Shwayder and State Representative Mary Ellen Epps. Some were implemented October 1, 1995, while others will require rule changes by the Colorado Board of Health.

The biggest change involves regular preparation and release of summaries of incidents reported to the division on unexplained deaths or serious injuries. The summaries will be released once the division has concluded its investigation or has determined that no further investigation is warranted.

Beginning October 1, 1995, summaries of reported incidents occurring on and after that date are to be prepared by division staff and sent to the facility for review and comment. Facilities will have seven days in which to review the summary and send comments back to the division. Summaries will then be placed in facility files for public viewing.

In order to free up staff time for summary preparation, the division will seek two rule changes from the Board of Health: 1) that the 24-hour reporting requirement for falls which result in fractures, dislocations, concussions or deep lacerations be changed to a written report submitted within seven days of the fall; 2) a proposal to eliminate the six-month statistical reports on less serious incidents. Initially, the division will not prepare summaries of falls. Reports on falls must be written and mailed or faxed to:

Liz Lambrecht, Health Facilities Division
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, Denver, CO. 80222-1530
or faxed to Liz Lambrecht at 303-782-4883.

Comments on summaries can be phoned in to:

Donna Burgess, Health Facilities Division
303-692-2916 or faxed to her at 303-782-4883

By November 1, 1995, consumers will be able to access all public information related to a specific licensed facility by visiting the department's Information Center, located in Denver at 4300 Cherry Creek Drive South, Building A, first floor. Files on each facility, organized by city, will contain ownership information, facility profiles, survey results, deficiency lists, plans of correction, complaint investigation summaries and summaries of reported incidents.

For general questions, call Jackie Starr-Bocian, Public Information Officer, Health Facilities Division, at 303-692-2853.

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N

o Good Deed Goes Unpunished

by Barry M. Manuel, MD,* FACS
Boston, MA

The old and anonymous proverb in the title has been quoted many times, and is certainly appropriate to describe a situation that was faced recently by a group of well-intentioned retired physicians in Massachusetts.

Acknowledgment

This article is an expanded version of an editorial by the author that appeared in the October 21, 1994, issue of the Wall Street Journal. Reprinted from the *Bulletin of the American College of Surgeons*, Volume 8-0, Number 10, October, 1995.

Physicians today are retiring at younger ages in increasing numbers. The most commonly cited reason is the difficulty of practicing medicine in the United States today due to the complexities of practice in a rapidly changing health care environment and rising professional liability claims.

An underutilized natural resource is developing as the ranks of these retired physicians swell. Many of these physicians left practice in the prime of their careers and are currently searching for opportunities to voluntarily contribute to society.

In response to this trend, professional organizations such as state medical societies are developing programs to utilize the experience and skills of retired physicians on a voluntary basis to address community needs.

By far the most popular activity among retired physicians is practicing medicine in underserved areas where they can utilize their skills without concern for paperwork, professional liability, and so on. Other volunteer activities of interest include speaking to students, seniors, church groups, and club groups on a variety of health care topics and volunteering services to departments of public health, neighborhood health centers, and physicians' health programs.

In Massachusetts, a strong demand for more volunteer opportunities by retired physicians led the Massachusetts Medical Society to send out an invitation to all known retired physicians in the state to join an organized volunteer effort to

donate their time for community service. The response was heartening, as some 600 physicians expressed interest, with the majority indicating a desire to practice medicine in underserved areas. As plans were proceeding, the need to protect volunteer physicians from potential professional liability actions was identified since most retired physicians no longer carry professional liability insurance. The issue was not considered serious, however, since these physicians would be serving pro bono and liability protection seemed a small price to pay for this service.

Recently, the Massachusetts Medical Society introduced legislation that would grant immunity from a professional liability action for ordinary (not gross) negligence for physicians who donate their time and practice in under-served areas. The immunity would be limited to those activities associated with this volunteer activity.

Expectations by the medical profession were high for passage of this legislation, but vigorous opposition by trial lawyers prevented the legislation from emerging out of committee.

At a time when access to health care is such an important priority for the American people and our political leadership is working diligently to accomplish this goal, how can any group put their own nepotistic interest above the health and welfare of the most disadvantaged and vulnerable members of our society?

No Good Deed Goes Unpunished (Continued)

At present, nine states—Florida, Illinois, Iowa, Kentucky, North Carolina, South Carolina, Utah, Virginia, and Washington, as well as the District of Columbia—have passed legislation granting immunity to physicians who provide free care in a clinic or similar setting. In Illinois, the legislation has been in place since 1987 and has not been challenged in the courts. Several states utilize various forms of sovereign immunity and good samaritan laws to protect volunteer physicians providing elective free care. In at least two states, Washington and Kentucky, a state pool subsidizes professional liability premiums for physicians who volunteer their services. In Washington, the state funds the pool and since its inception in 1989 no claims have been filed. In Kentucky, the legislation was enacted in the spring of 1994 and the pool is funded by a \$1 fee collected from all physicians and attorneys. In the short time since its enactment, no claims have been filed. In general, however, the majority of states provide no protection for physicians who volunteer their services to care for the underserved.

On the federal level, the Federally Supported Health Centers Assistance Act of 1992 provides liability protection for certain health care professionals and entities. In addition, former Sen. John Danforth (R-MO) introduced the Charitable Medical Care Act of 1994 (S2536) in the 103rd Congress. This piece of legislation would "encourage the furnishing of health care services to low income individuals by exempting health care professionals from liability for negligence for health care services provided without charge, except in cases of gross negligence or willful misconduct, and for other purposes." Unfortunately, the legislation died in the 103rd Congress and, to date, similar legislation has not been reintroduced.

The effort to protect volunteer physicians who provide elective free care is not a new concept and is actually based on existing good samaritan laws. Currently, all 50 states and the District of Columbia have adopted some form of good samaritan legislation to protect volunteer physicians from ordinary negligence liability when providing emergency care to an individual. Current efforts would simply expand this protection to physicians providing pro bono care in underserved areas to the uninsured and underinsured population.

Volunteerism by physicians has never been more critical or its impact more significant. It has been estimated that charitable medical care meets the needs of 30 percent of the currently uninsured population. Admittedly, this effort by physicians will not solve all the medical problems of the 37 million Americans without health insurance, but it would be a beginning and perhaps could stimulate an even greater voluntary effort by others.

The Massachusetts Medical Society is again planning to reintroduce legislation protecting the activities of those physicians who volunteer their time to administer to the poor and sick. Let us hope that the plight of the disadvantaged will win out over the nepotistic interests of a small but powerful professional group and that the proverb, "No good deed goes unpunished," will not hold true.

*** Dr. Manuel is associate dean and professor of surgery at Boston (MA) University Medical Center. He is also a member of the College's Regental Committee on Professional Liability.**

This space contributed
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"YES, THERE IS LIFE AFTER BREAST CANCER. AND THAT'S THE WHOLE POINT."

—Ann Jillian



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Life is just too wonderful to give up on. And, as I found out, no woman has to give up on any of it. Not work, not play, not even romance.

Oh, there is one thing, though.

Your patients have to give up being afraid to take care of themselves. And you can help them do it.



Get a checkup. Life is worth it.



Salute

Frederick A. Lewis, Jr., M.D., honored on his retirement

Frederick A. Lewis, Jr., M.D. has been a member of the Colorado Medical Society (CMS) since 1957 when he was the Chief of Inpatient Psychiatric Service at Denver General Hospital. He joined Denver Medical Society the same year.

In addition to his various medical associations and positions with the University, hospital medical and psychiatric staffs, with the American Psychiatric Association and the Colorado Psychiatric Society, Fred:

- Served as President of the Colorado Foundation for Medical Care (CFMC), Region II Council, 1974-1975
- Served as a member of the CFMC Board of Directors 1974-76 and 1977-79
- Served as Chairman of the Board, CFMC in 1978
- Member of the Denver Medical Society (DMS) Council from 1968 to 1978
- Member of the Board of Censors, 1969-1971
- served as Secretary, DMS, in 1972-1974
- Was elected Vice President, DMS in 1974.
- Served as President in 1976-77
- Became Chairman of the DMS Board of Directors in 1977-78
- Served on the CMS Mental Health Committee from 1962 to 1967.
- Was Vice Chairman in 1962-63, and Chairman from 1964 to 1967
- Was a member of the CMS Public Health Council from 1967 to 1971
- Was a member of the Ad Hoc Health Personnel Licensure Committee in 1973-1974
- Became a member of the CMS Board of Trustees in 1978
- Was elected President-elect in 1980, and served as President in 1981
- Served on the Socio-Economic Council in 1977-1978
- Was a member of the CMS House of Delegates from Denver 1968-1978

After 1980, most of Fred's organization energies were taken up by helping to form the Copic Insurance Trust. He was a member of the original Board of Directors and still serves that position today. He then continued on the Board when Copic became Copic Insurance Company.

In 1993, Fred was appointed as Chairman of the Colorado Medical Society Council on Legislation, and served in that position for one year.



Dr. Fred Lewis listens as K. Mason Howard reads from a plaque commemorating Dr. Lewis' outstanding service to Colorado Medical Society, Copic Insurance and other organizations of medicine. Dr. Lewis retired on October 31st and was honored at a luncheon at Copic headquarters.

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Physicians and Physician Assistants: Working Together

What are the guidelines for the Physician/PA relationship?

For over 28 years, physicians and physician assistants (PAs) have been working together throughout the United States. Though this concept of team care is becoming more routine, questions still remain about this working relationship. A future edition of *Colorado Medicine* will have an article on reimbursement issues related to physicians working with PAs. This article will look at some recent changes to the working relationship between these two professions.

To clarify this relationship, the AMA's House of Delegates adopted, in June, model guidelines to help the supervising physician understand how the physician/PA team should work. Additionally, the Colorado Board of Medical Examiners recently adopted regulatory changes expanding the physician's delegatory power regarding PAs to include allowing PAs prescribing privileges for controlled substances.

The AMA guidelines are "based on the unique relationship of physician assistants who recognize themselves as agents of physicians with respect to delegated medical acts and legal responsibilities." In general, the guidelines stress two major points. First, the physician is responsible for managing the care of patients and for the supervision of the PA. Second, the role of the PA in the delivery of care should be defined through mutually agreed upon guidelines developed together by the physician and the PA.

Lynn Caton, national president of the American Academy of Physician Assistants, pointed out, "In its

adoption of these guidelines, the AMA affirms the contributions made to quality patient care by the physician/PA team in a rapidly changing health care environment." He added that the PA profession welcomes these guidelines because they emphasize the positive aspects of the team approach to health care.

In Colorado, the PA may perform medical functions as delegated by the supervising physician, including the writing of prescriptions. **Recent regulatory changes allow a physician to delegate prescribing of controlled substances, schedule II through V "as long as the supervising physician has issued written protocols specifying which medications are used in the practice and which may be prescribed by the PA on both a case by case and per patient visit basis."** **Prescription pads utilized by PAs NO LONGER need to have the name of the supervising physician on the pad.** (Contact Suzanne Hamilton at CMS for a copy of the revised regulations.)

As in the past, the supervising physician must provide **direction** to the PA in order to specify what medical services should be provided under the circumstances of each case. Direction may be provided either in person, by written protocol, over the phone or through other electronic means and medical records must be reviewed every three working days. The physician is also required to provide **adequate supervision** of the performance of delegated medical functions. There is a presumption, on the part of the

In Colorado, the PA may perform medical functions as delegated by the supervising physician, including the writing of prescriptions.

BME, that the supervising physician is present at the location where the PA practices at least every third working day. In circumstances where on-site supervision is not provided, the burden is on the physician or the PA or both to establish that the lack of such supervision was reasonable under the circumstances. Additionally, the supervising physician is required to review medical records every third working day to assure compliance with the licensed physician's directions. (Note that these are the general guidelines and there may be exemptions for certain practice sights such as correctional institutions and federal rural health clinics.)

Today, there are over 700 PAs practicing in Colorado. According to the American Academy of Physician Assistants 1995 Annual Census, over 39% of the PAs in the state work for group practices, 11% work for solo-physician practices, 11% for staff model HMOs and managed care organizations, 8% for military facilities, and 7% for hospitals. Twenty-eight percent of the PAs work in communities with fewer than 50,000 residents. Broken down by specialty, the largest group of PAs (41%) practice family and general medicine, followed by 21% in surgery or the surgical subspecialties, 8% in both emergency medicine and general medicine, and 5% in general internal medicine.

Thanks to Nancy Hughes of the AAPA for her assistance with this article.

AMA Guidelines for Physician/PA Practice

Reflecting the comments from the American Academy of Physician Assistants, separate model guidelines for Physicians/ PAs practice have been developed. These are based on the unique relationship of Physician Assistants who recognize themselves as agents of physicians with respect to delegated medical act and legal responsibilities. They are consistent with the existing AMA policies concerning physician assistants cited in this report. In all settings, Physician Assistants recognize physician supervision in the delivery of patient care. The suggested guidelines reflect these considerations as follows:

1. The physician is responsible for managing the health care of patient in all practice settings.
2. Health care services delivered by physicians and Physician Assistants must be within the scope of each practitioner's authorized practice as defined by state law.
3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Physician Assistant, ensuring the quality of health care provided to patients.
4. The physician is responsible for the supervision of the Physician Assistant in all settings.
5. The role of the Physician Assistant(s) in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the Physician Assistant and based on the physician's delegatory style.
6. The physician must be available for consultation with the Physician Assistant at all times either in person or through telecommunication systems or other means.
7. The extent of the involvement by the Physician Assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patients condition and the training and experience and preparation of the Physician Assistant as judged by the physician.
8. Patient should be made clearly aware at all times whether they are being cared for by a physician or a Physician Assistant.
9. The physician and Physician Assistant together should review all delegated patient services on a regular basis , as well as the mutually agreed upon guidelines for practice.
10. The physician is responsible for clarifying and familiarizing the Physician Assistant with his/her supervising methods and style of delegating patient care.

Adopted by the AMA House of Delegates, June 1995



HEALTH DEPARTMENT

Nancy Henderson, MSW, Coordinator,
Osteoporosis Prevention Project, Division of Prevention Programs

Osteoporosis Grand Rounds

- Dec. 1 Grand Junction
7 am Community Hospital
(970-242-0920)
Steve Ecklund, MD
- Dec. 1 Greeley
Noon North Colo. Med. Ctr.
(970-356-2424)
Margaret Wierman, MD
- Dec. 4 Thornton
8 am North Suburban Hospital
(303-451-7800)
Walter Briney, MD
- Dec. 8 Denver
Noon Presbyterian-Saint Luke's
(303-839-6741)
Paul Miller, MD
- Dec. 19 Grand Junction
7 am St. Mary's Hospital
(970-244-2273)
Paul Miller, MD
- Jan. 12 Loveland
Noon McKee Medical Center
(970-635-4041)
Walter Briney, MD

(For information on additional
presentations call 303-692-2590)

Osteoporosis Media Campaign

Soon, your patients will be asking you about osteoporosis

Why? In January, 1996, the Colorado Department of Public Health and Environment Osteoporosis Prevention Project and the Western Dairy Council will be conducting a media campaign using local newspapers, as well as radio and television stations, to help promote awareness of osteoporosis and available prevention and treatment methods.

Now is the time to bone up

Obtain up-to-date information on osteoporosis prevention, diagnosis and treatment. Attend a local presentation or call 303-692-2590 or fax 303-782-0095, attention Nancy Henderson for the following free publications:

1. **Osteoporosis in Postmenopausal Women: Pathophysiology, Prevention, and Management.** Morris Notelovits. *Clinical Geriatrics*, August 1994 (CME credit)
2. **Optimal Calcium Intake.** NIH Consensus Statement, August 1994. (CME credit) or 2 page summary
3. **Consensus statements** on exercise, calcium, vitamin D, estrogens and hormone replacement, calcitonin, bisphosphonates, fluoride, and anabolic steroids. National Osteoporosis Foundation
4. **Practical Utilization of Bone Densitometry for Adults.** Paul Miller in *Osteoporosis Clinical Updates* 1996, in press. Preprints available.
5. **List of dual energy X-ray absorptiometry (DEXA) bone densitometry sites in Colorado, and Summary of Medicare DEXA Reimbursement Guidelines,** Metabolic Bone Disease Society of Colorado.
6. **Weighing the Benefits and Risks of Hormone Replacement Therapy after Menopause.** David Grimes, ed. *The Contraception Report*, September 1995. (CME credit)
7. **New Concepts in Managing Menopause (Suppl.)** Leon Speroff, MD., et al. *Contemp. OB/GYN and IM Int. Med. and Patient Care*, November 1995. (CME credit)
8. **Breaking the Risk of Falls: an Exercise Benefit for Older Patients.** C. Pollock. *The Physician and Sports-medicine*, November 1992. (4 pp.)
9. **Patient handouts.** National Osteoporosis Foundation



George Carnes, Radiation Control Division
Colorado Department of Public Health and Environment

X-Rays Make Double History

The Department of Public Health and Environment will commemorate the 100th anniversary of the discovery of x-rays with the completion of its first year of Mammography Quality Standards Act (MQSA) inspections. The department, in cooperation with the Food and Drug Administration (FDA), has been able to verify an document that the quality of mammography in Colorado is high. The number of problems have been few, usually of a minor nature, and all have been promptly corrected by the facilities in question.

Mammography, which represents x-ray technology in its most advanced form, is a long way from the first crude medical uses of x-rays that began almost immediately after their discovery in 1895. On November 8th of that year, Wilhelm Conrad Röntgen, experimenting with an evacuated Hittorf-Crookes tube, observed that an invisible ray was penetrating the opaque cover he had placed around the device and was causing a fluorescent screen to glow. Röntgen had discovered radiation; specifically, x-rays. This discovery, and his subsequent investigation and characterization of x-rays, earned Röntgen the very first Nobel Prize in physics in 1901. He could have made a fortune from his discovery, but instead donated his prize money and chose not to patent his discov-

ery. His philanthropy allowed medical applications of x-rays to begin immediately, and the quality of medical care and diagnosis to make tremendous strides forward.

Where would we be without x-ray technology? The only certain answer is that medical and dental care would be vastly different from what we have come to expect. A great deal more diagnosis and preventive care would be carried out by supposition and exploration. In the history of modern medicine, x-rays are truly a miraculous addition to the tools available to our health professionals.

The Colorado Department of Public Health and Environment maintains an X-ray Registration and Compliance Program to insure that the x-rays Coloradans receive come from machines that are safe and routinely inspected. The program is unique in that the actual inspections of x-ray machines are carried out by private individuals certified as qualified by the department. This program monitors not only mammography facilities, but all medical, dental, chiropractic, veterinary, and industrial facilities that use x-ray machines. If you would like more information regarding the department's x-ray program, please call the X-ray Program Help Desk at 303-692-3075.

Successful mammography program marks 100th anniversary of the discovery of x-rays.



NEW MEMBERS

WELCOME!

Here are the names of your colleagues who have joined the Colorado Medical Society because of a recent trial membership offer. The idea was that the best way to convince a physician of the value of CMS membership was to let him or her experience it. Part of that experience should be in networking with other CMS physicians. If you recognize any of these names, be sure to congratulate that physician on making the right choice in joining the CMS.

CLEAR CREEK VALLEY MEDICAL SOCIETY

E. Sam Fishman, M.D.
Glenn T. Kimata, M.D.
Robert F. Murch, M.D.
Lawrence M. Pertcheck, M.D.
C. Frazer Shipman, M.D.
Robert E. Wright, M.D.

DENVER MEDICAL SOCIETY

Mitchell D. Achee, M.D.
Anthony L. Angello, M.D.
Jeremiah A. Bartley, M.D.
M. Dennis Barton, M.D.
Wendy K. Berenbaum, M.D.
Mark P. Berland, D.O.
Raymond N. Blum, M.D.
Bryan C. Bomberg, M.D.
Ely Brand, M.D.
Robert E. Brown, M.D.
William C. Brown, M.D.
John P. Campana, M.D.
Alan S. Feiner, M.D.
Herbert I. Fried, M.D.
Patricia A. Giuffre, M.D.
Reid A. Goodman, M.D.
Stanley N. Goodman, M.D.
Jean Marie Greos, M.D.
Albert P. Hattem, M.D., MBA, MS
Carol Ann Hauk, M.D.
Edward P. Havranek, M.D.
Harrison F. Hayes, M.D.
Linda C. Huang, M.D.
Terri L. Ingram, M.D.
Robert C. Jacobs, M.D.
Jacqueline Jamison, M.D.
Eric R. Jamrich, M.D.
Johnny E. Johnson, M.D.
Alan E. Lazaroff, M.D.
James E. Leibold, M.D.
George R. Lesznik, M.D.
Hal B. Levy, M.D.
Ronald G. Lewis, M.D.
Anthony J. Logalbo, M.D.
Andrew Mallory, M.D.
Pam McCroskey, M.D.
William B. McIlvaine Jr, M.D., CMFRC
Paul G. Moe, M.D.
Gary R. Morris, M.D.
William F. Orr Jr, M.D.
Richard K. Park, M.D.
Edward H. Parks, M.D.
Jan J. Perloff, D.O.
Bruce E. Piatt, M.D.

Nelson Rangell, M.D.
James M. Robinson, M.D.
Chester T. Roe III, M.D.
Donna A. Rosenberg, M.D.
William H. Rosewater, M.D.
John C. Roth, M.D.
Leo J. Rothbarth, M.D.
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John H. Sobel, M.D.
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Chester S. Kucinski, M.D.
William J. Mandell, D.O.
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Sebastian Rodriguez, M.D.
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Peter A. Schunk, M.D.
Gregg E. Springer, M.D.
Lloyd L. Strode, D.O.
John R. Wright, D.O.

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Roger W. Davis, M.D.
Hernan Morales, M.D.
Michael T. Rendler, M.D.
Donn A. Rouge, M.D.
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On this and the following pages, you will find the names of those physicians who have joined the medical society since our last report.

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Of course, informed consent is still the responsibility of the physician. No computer program or written form can replace actual physician-patient contact. The program is just one more tool to help the physician communicate with the patient, while the informed consent form merely records the results of that communication.

For more information about this technology, call Dave Muir of Patient Software at 415-597-4380.

"Smoke Detectors Provide Critical Seconds To Escape"

As winter approaches, the Colorado Department of Health & Environment/Emergency Medical Services Division and Division of Fire Safety want to remind residents to make another change that could save their lives- changing batteries in their smoke detectors.

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Doctors, please inform your patients. Changing smoke detectors batteries once a year is one of the simplest, most effective ways to reduce these tragic deaths and injuries. In fact, a working smoke detector cuts the risk in a home fire by nearly half.

Nominations Sought

The Colorado Department of Public Health & Environment is seeking nominations for outstanding community health promotion programs and volunteers in Colorado.

Nominated programs should meet the following criteria including evidence that program objectives are based on well-defined problems derived from baseline data or evidence of community need; evidence that objectives and intervention strategies are appropriate; evidence that the program is effective in terms of its implementation,

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For nomination forms, call Pat Allen, Colorado Department of Public Health & Environment, Prevention Programs at (303) 692-2501. Nominations should be received no later than January 12, 1996.

Hospice Helps Families

Discussing with parents issues of aging, illness, living wills, finances, and power of attorney may seem difficult and awkward. But in the event that terminal illness or death strikes unexpectedly, planning ahead may help ease the strain places on families and friends, and eliminate the need to make tough decisions under duress.

However, with so many complicated issues to resolve, families may not know where to turn for help. One resource available is hospice, a program of care that helps patients and their families maintain the best quality of life during the illness and after the patient's death.

Colorado Hospice Organization is a nonprofit corporation dedicated to promoting the hospice program of care and serving as an advocate for the terminally ill and bereaved. For the name of the hospice nearest you, contact Colorado Hospice Organization at (303) 620-5144.



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For more details, call **(800) 864-4388**. In Denver, **753-0440**.

Colorado Medical Society

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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

In Celebration!



Francis T. Candlin, DVM

There is not a great deal that can be said by the likes of me concerning the life of one such as Francis Candlin. If you knew him you would immediately agree. If you didn't know Dr. Candlin, you truly missed one of life's joys. Dr. Candlin died at home in Denver October 21st.

I knew Dr. Candlin for over 40 years and in all that time, he was one of the constants in my life: I knew exactly what to expect. That relationship never changed. It was always a pleasure seeing him and talking with him. I can't say that about very many people I have known that length of time.

What made him so special? There were lots of things, but I can't name them. The most memorable was that Francis was always genuinely interested in me; I don't mean that to be one of my considerations for liking a person, that they're so interested in me. With him, like so many people, his interest in his fellow creatures was apparent in everything he did. He expressed it without trying.

There were many times when I saw him that he wouldn't even offer a salutation. It was as though our last conversation had never ended; I was immediately comfortable. He would tell me a funny story and we would enjoy a good laugh. The stories were never a chance of offending me or anyone in my company. They were often stories that directly involved him. He could laugh at himself just as easily as anyone. Many of the stories involved animals because he had a great feeling for them, as well. What a great way to relate to people. Generally, people just don't like to

be all that serious. A humorous story told for the fun of it is a much better way to relate. Francis was a master at relating because he enjoyed seeing people feel good, if only for a short time. We could always get serious afterward.

Dr. Candlin was a longtime activist in the PAC movement, both in his veterinarian organizations and in Colorado Medical Society. He was the only non-physician to ever receive the CMS Certificate of Service. The CMS membership thought a lot of him. Dr. Robert Sawyer, COMPAC Chairman, just published a statement written by Dr. Candlin in the October issue of **Colorado Medicine**. He also paid tribute to Dr. Candlin's work on behalf of the medical PAC.

Dr. Candlin also served as president of the Denver Board of Health and Hospitals and he served on the Colorado Public Health Association. Dr. Candlin had many friends in Colorado's medical community and at large. He was just a very likeable person and I'll remember him so well for that.

We'll all certainly miss him, but I, for one, will celebrate his life and what his friendship have meant to me. They meant (and still mean) a lot!

RISKS

TAXES INFLATION SUITABILITY PENSION RULES COLLEGE COSTS

“Financial Strategies for Successful Retirement”

Seminar covering:

THE 9 BIGGEST MISTAKES PROFESSIONALS MAKE WHEN PLANNING FOR RETIREMENT AND HOW TO AVOID THEM!

Tuesdays: January 16, 23, 30, & February 6, 6:30 to 8:30 PM

OR

Thursdays: January 18, 25, & February 1, 8, 6:30 to 8:30 PM

In an effort to assist physicians, pharmacists and chiropractors in planning for retirement, the Greater Rocky Mountain Group will moderate **four two-hour sessions** to be held at **The Colorado School of Pharmacy Auditorium**, 8th Avenue and Colorado Boulevard, Denver, Colorado. **The seminar is designed for professionals of all ages.** Each session discusses different topics (complete agenda available upon request), so you will want to attend all four sessions. Classes are practical, enjoyable and non-threatening. There is no attempt to sell you specific investments or insurance products. Attendees are under no obligation before, during or after the seminar.

REGISTRATION

Save Money By Registering Early!

(Save \$40) Register by Jan. 9, 1996 - Tuition is **\$59**

(Save \$29) Register by Jan. 15, 1996 - Tuition is **\$79**

Register at the door (if seating available) - Tuition is **\$99**

**100% MONEY BACK GUARANTEE
IF NOT COMPLETELY SATISFIED**

Tuition Includes Spouse

To Register:

Phone Lisa Smith, 770-9970, 8 AM - 5 PM, weekdays

OR

FAX this completed form to 770-7721 at any time.

Name: _____

Address: _____

☐ Master Card ☐ Visa
Card#: _____ Exp. Date: _____

Signature (required): _____

☐ My schedule does not permit me to attend the February/March seminar. Please let me know of the next seminar. (I have written my name and address above).

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Endorsed by The Denver Medical Society

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COLORADO MEDICINE

"Advocating excellence in the profession of medicine"

June, 1995

Volume 92, Number 6

FFSM

Vs.

MSOs

SEPTEMBER 7-10, 1995

ASPEN, COLORADO

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PROVIDENCE RI 02912

BROWN UNIVERSITY
JUN 20 1995





COLORADO MEDICINE

June, 1995

Volume 92, Number 6

In This Issue...

It's the Fee For Service home team against the strong challenger of Managed Service Organizations. The future of medicine will be shaped by the outcome of this contest. The 125th Annual Meeting of the Colorado Medical Society is structured to help you and your teammates face off against the forces that want to take control of your practice and your future. Look inside for more tools to help you get back in the game and win. Play Ball!



THE RITZ-CARLTON

ASPEN

PHONE (970) 920-3300

Babysitting Available

The Ritz-Carlton provides a nanny service in the hotel. Staffed by hotel employees, the service must be booked in advance. The cost is \$12 per hour, with a two hour minimum and an extra \$1 per hour charge for each additional child. Call the Ritz-Carlton in Aspen at 303-920-3300 to arrange for this service.

Attention: Physician Spouses

The Colorado Medical Society Alliance is sponsoring several events of interest to physician spouses at this meeting. Look for information and registration in this issue. These events are open to all Alliance members and any interested spouses of physicians.

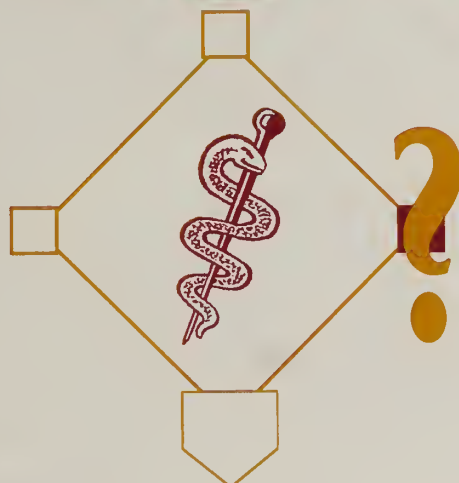
See additional activity listings elsewhere in this issue.

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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Michael Thompson, Asst. Managing Editor, Gil Maestas, II, Communications Specialist

WHO'S ON FIRST?



Colorado Medical Society Annual Meeting Educational Program

Saturday, September 9, 1995

Ritz Carlton, Aspen

Who's on First?

(or What Opportunities Will You Have to Practice Medicine in the Future?)

8:00 am - 8:10 am	Welcome and Introduction— Joel M. Karlin, MD, CMS
8:10 am - 8:25 am	Overview— Joe Aita, MD, Lifeguard
-	Presentations:
8:25 am - 8:45 am	Dick Wright, PhyCor
8:45 am - 9:05 am	David Vandewater, Columbia/HCA
9:05 am - 9:25 am	Mark Donahue, PruCare
9:25 am - 9:45 am	Toby Cole, MD, Kaiser Permanente
9:45 am - 10:05 am	David Ginsberg, Healthcare Consulting
10:05 am - 10:25 am	Break
10:25 am - 10:55 am	Breakout groups headed by each of the presenters so attendees can ask questions in small group setting
10:55 am - 11:25 am	Panel discussion moderated by Dr. Aita—panelists to highlight questions/information from breakouts
11:25 am - 11:55 am	Q&A
11:55 am - 12:00 N	Concluding remarks— Joel M. Karlin, MD

CMS Annual Meeting Golf Tournament

at Aspen Golf Course
Thursday, September 7, 1995
Entry Form

Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____ Home Phone _____ FAX# _____

(Needed for tee times)

While in Aspen I will be staying at _____

I will be attending the meeting in the capacity of (check one)

☐ Physician

☐ Exhibitor

☐ Spouse

☐ Other

I will:

☐ Sponsor a golf course hole @\$100

☐ Sponsor a putting green contest hole @\$50

Name of sponsor (as you wish it to appear on sign)

(Professionally made signs will be displayed for sponsors.)

My golf handicap is _____

I will require rental clubs @ \$60

(Big Berthas may be available)

☐ USGA

☐ Other

☐ Left handed

☐ Right handed

Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference of who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament entry, registration form and advance payment of \$100 must be received **no later than** August 21, 1995. Cancellations received after August 21, 1995 are refundable subject to ability of Aspen Golf Club to "resell" vacated tee times.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at 970-925-2145.

I prefer to be teamed with _____

* Mail Entry Form and check to Media Specialties, P. O. Box 36357, Denver, CO 80236. For additional information, call Tim Jackson at 303-986-5926.

Women in Medicine Section

Saturday, September 9—12:30 – 3:00 pm

Lunch/Business Meeting

ACES—Aspen Center for Environmental Studies.



Lunch will be catered by the Acme Noodle Company (cost \$10). The business meeting will be followed by a guided tour of the Aspen Center for Environmental Studies (the tour costs \$5). The tour of this outdoor center will include the opportunity to see endangered birds of prey and typical lake/stream ecosystems. For information, call Kirsten Spilde at the Colorado Medical Society, 303-779-5455 or 1-800-654-5653.

BATTER UP!



A Reception

Thursday, September 7, 1995 6:00 pm

You are invited to come, dressed as your favorite baseball character, Babe Ruth, Hank Aaron, Andres Gallaraga, the ball, home plate, or even the backstop if you are large enough. See if you can still fit into your old high school or college uniform, or just put on a ball cap and come to the party!

This is your time to get acquainted with your colleagues and their families before the official business of the meeting gets started. Check the box on your registration form today and start looking for that old Denver Bears jersey.

When it's time to take a break from the game...

there are plenty of things to do in the Aspen area. Whether your interests run to fishing, art, dance, music, glider or balloon rides, mountain biking, hiking, dining, rafting, kayaking, shopping or just about anything else that's legal to do indoors or outdoors, you'll probably find somewhere to do it in the Aspen area.

In addition to the many services and activities available at the Ritz-Carlton itself (970-920-3300), you may find many others to your liking in the surrounding community and mountain areas. Call the Aspen Chamber Resort Association at 970-925-1940.



Join Us Saturday Night for Your 7th Inning Stretch



"Puttin' on the Ritz"
at the
President's Dinner Dance
Saturday, September 9
7:00 pm
Ritz Carlton
Ballroom

Meet the Sirens...

and their sensational retro sound at the President's Dinner Dance. Five outstanding musicians on drums, bass, electric guitar, keyboards and sax provide a tight and lively instrumental foundation for the songs and choreography of three beautiful, talented divas. This eight-piece powerhouse not only will draw you in and get you on your feet dancing, but leave you begging for more as well.

Based in the Aspen area, the Sirens provide sounds that all ages enjoy, tastefully delivering prime selections from the 40s through the 90s. This exciting band dynamically glides through swing and jazz, country, rock, Motown, blues and funk with refreshing style.

The Sirens, with tight vocal harmonies, penetrating vocal and instrumental solos, and overall musical versatility, will make "Puttin'on the Ritz" an evening to remember.





Colorado Medical Society
Annual Meeting
September 7-10, 1995



THE RITZ-CARLTON

ASPEN
PHONE (970) 920-3300

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ No of Guests _____

Arrival Date _____ at _____ (Check in time is 3:00 pm)

Departure date _____ at _____ (Check out time is 12:00 noon)

☐ \$125 Single or double occupancy
Rates are per room, per night

☐ King Bed ☐ 2 Double Beds
☐ Smoking ☐ Non-Smoking
Rates do not include the room tax currently 11.2%

ADVANCE DEPOSIT REQUIRED TO CONFIRM RESERVATIONS.

Method of payment:

☐ American Express
☐ Diners Club

☐ MasterCard
☐ Carte Blanche

☐ Visa
☐ Check enclosed

Account Number _____ Expiration date _____

Credit cards will be charged at the time the reservation is made.

Signature of Card Holder _____

Deposit: Each reservation must be accompanied by a two-night deposit which will be applied to the first and last night's stay. Deposits are to be received no later than August 18.
Deposits are refundable if reservations are canceled more than 7 days prior to arrival. All deposit money is non-refundable if a cancellation is made within 7 days of the arrival date.
Reservation Cutoff: Rooms will be held for the attendees of Colorado Medical Society at this special rate until August 18. Reservations received after this date will be accepted on a space available basis at the group rate.

Special requests _____

You spent over
8 years in school,
over 300 all-nighters studying,
4 years in residency,
countless years working 7 days a week,
thousands of hours on call,
who knows how much in tuition,
and an unspeakable amount
in student loans.

Now, think how fast a malpractice suit could
jeopardize all you've worked for.

Copic knows how quickly a malpractice claim or suit could play havoc with a lifetime of hard work. That's why we do everything we can to help you avoid ever being involved in one. Our professional liability insurance includes an in-depth risk management program. We offer risk management seminars, office risk management consultations, and telephone availability of physician risk

managers. We'll personalize your coverage to ensure your practice is properly protected at a reasonable rate. And, should a claim or suit ever be brought, we will be there for you every step of the way – from the first notice until the matter is resolved. We work hard to avoid unjustified settlements, protect your reputation, and make sure your dream of practicing medicine never turns into a nightmare.



Copic Insurance Company

Call our Underwriting and Policyholder Service Department at (303) 779-0044 or 1-800-421-1834.

COLORADO MEDICAL SOCIETY AND COLORADO MEDICAL SOCIETY ALLIANCE

Tentative 1995 Annual Meeting Line Up

Ritz Carlton Aspen
September 7-10, 1995

THURSDAY, SEPT. 7

8:00 am --- CMS Office open
12:48 pm --- 18 hole Golf Tournament
4:30 pm --- 8:00 pm Registration open
6:00 pm --- 7:30 pm "Batter Up" Reception
7:30 pm --- Dinner on your own

NOTE: Dress for Annual Meeting

Thursday evening

reception: baseball attire or casual

Friday: casual

Saturday morning: casual

Saturday inaugural

dinner/dance: black tie preferred

Sunday: casual

FRIDAY, SEPT. 8

7:00 am --- CMS Office opens
7:00 am --- 5:00 pm Registration
7:00 am --- 8:30 am El Paso County Caucus
7:15 am --- 8:15 am Reference Committee Breakfast
8:00 am --- 12:00 N Exhibits open
8:15 am --- 8:45 am Credentials Committee
8:30 am --- 9:30 am Alliance Board Breakfast
8:45 am --- 9:15 am Opening Session House of Delegates
9:15 am --- 11:45 am General Membership Meeting
9:45 am --- 11:45 am Alliance General Meeting
9:45 am --- 10:15 am Coffee break
12:15 pm --- 1:45 pm COMPAC/CMSA Luncheon
2:00 pm --- 4:30 pm Reference Committee*
2:00 pm --- 3:00 pm Alliance Workshop
2:00 pm --- 5:00 pm Army National Guard Physicians
2:15 pm --- 3:15 pm Copic Risk Management
2:15 pm --- 3:15 pm Copic Risk Management
3:00 pm --- 5:30 pm Reference Committee*
3:00 pm --- 4:30 pm Alliance County Breakout Sessions
3:45 pm --- 4:45 pm Copic Risk Management
3:45 pm --- 4:45 pm Copic Risk Management
4:00 pm --- 6:30 pm Reference Committee*
4:00 pm --- 7:00 pm Exhibits open
5:30 pm --- 7:00 pm Exhibitor Reception
6:30 pm --- 7:30 pm Colorado Society of Internal Medicine Annual Meeting
7:00 pm --- 9:00 pm Gone But Not Forgotten Dinner

**Number and starting times of Reference Committees subject to change depending on number of resolutions submitted*

SATURDAY, SEPT. 9

7:00 am --- CMS Office opens
7:00 am --- 11:00 am Registration
7:00 am --- 7:50 am Educational Program Continental Breakfast
7:00 am --- 11:00 am Exhibits open
8:00 am --- 12:00 N Educational Program "Who's on First? or What Opportunities Will You Have to Practice Medicine in the Future?"
8:00 am --- 12:00 N Alliance Meeting - "Unplug the Holiday Machine"
12:00 N --- Recreation Time golf, tennis, horseback riding, biking, fishing, walking, etc.
12:30 pm --- 2:00 pm Women in Medicine Meeting @ the Center for Environmental Studies
2:00 pm --- 3:00 pm WIM tour @ the Center for Environmental Studies (open to all)
1:00 pm --- 4:00 pm Copic Workshop-Physician Integration Phase II & Beyond
1:00 pm --- 4:00 pm Army National Guard Physicians
1:30 pm --- 3:00 pm Unified Grievance Committee
6:00 pm --- 6:30 pm Inaugural Address
6:30 pm --- 7:00 pm Cocktails cash bar
7:00 pm --- 10:30 pm Presidents' Dinner/Dance
9:30 pm --- 11:00 pm Copic Dessert Reception

SUNDAY, SEPT. 10

6:30 am --- Reference Committee Reports available
7:00 am --- CMS Office opens
7:00 am --- 10:00 am Registration
7:00 am --- 8:30 am Component Caucuses
Arapahoe
AuroraAdams
Boulder
Clear Creek Valley
Denver
El Paso
Larimer/Weld
Pueblo/Western Slope
8:00 am --- 8:30 a.m. Credentials Committee
8:30 am --- 12:00 N Closing Session HOD
9:00 am --- 10:00 am CMSA Gavel Club Breakfast
12:00 N --- or immediately following HOD Nominating Committee
12:00 N --- or immediately following HOD Reorganizational Board

OFFICE USE

- ☐ Delegate
☐ Alternate Delegate

Tentative Annual Meeting Registration

1995 Annual Meeting of the Colorado Medical Society and CMS Alliance
 September 7-10, 1995, Ritz-Carlton, Aspen, Colorado

Name (please print) _____

Name of Spouse/Guest(s) (if attending) _____

Component Society _____ Office Phone _____

If you are not a member of CMS, please provide the following:

Company/Organization _____ Title _____

Reservations for Events and Meetings

Reservation deadline is August 25, 1995. (Note: To attend the President's Dinner Dance on Saturday, you **must** obtain your tickets before noon, Friday, Sept. 8.) Reservations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders.

As a member, **you and one guest are entitled to attend the complimentary events at no charge.** Please indicate the number of additional guests at the bottom of this form and enclose your check.

Complimentary events open to all members:

THURSDAY, SEPTEMBER 7

6:00 pm Reception: Batter Up! member ☐ guest ☐

FRIDAY, SEPTEMBER 8

5:30 pm Exhibitor Reception member ☐ guest ☐

SATURDAY, SEPTEMBER 9

7:00 am Educational Program Continental Breakfast member ☐ guest ☐

8:00 am Educational Program: Who's on First? member ☐ guest ☐

4:30 pm CMS Alliance Reception member ☐ guest ☐

(for Alliance members & interested spouses)

7:00 pm President's Dinner Dance: **Putting on the Ritz** (Black tie preferred)

(Reservations necessary, please select menu below)

Beef Dinner, or member ☐ guest ☐

Chicken Dinner member ☐ guest ☐

9:30 pm Copic Dessert Reception member ☐ guest ☐

Additional Reservations (other than member + 1 guest):

Reception: Batter Up! # _____ @\$10 each= _____

Educational Program Breakfast # _____ @\$15 each= _____

President's Dinner Dance (Reservations necessary, please select menu below)

Beef Dinner, or # _____ @\$50 each= _____

Chicken Dinner # _____ @\$50 each= _____

..... Total for Additional Reservations \$ _____

Non-Complimentary Events:

Cost

Number

FRIDAY, SEPTEMBER 8

8:30 am CMSA BOD Breakfast \$30 each _____

12 Noon COMPAC/CMSA Luncheon \$25 each _____

..... Total for Non-Complimentary Reservations \$ _____

Total enclosed for non-complimentary and/or additional reservations \$ _____

After completing this form, please mail it to us (at PO Box 17550, Denver, CO 80217-0550), phone it to us (at 303/779-5455 or 1-800/654-5653) or FAX it to us (at 303/771-8657).



"Who's On First?"



Sandra L. Maloney
Executive Director
Colorado Medical Society

Abbott and Costello, though not CMS members, accurately described the current state of the business of medicine. Just when you think you've got it figured out, someone changes the rules... again. We've structured the activities at this year's Annual Meeting to be your program and scorecard for the '90s and beyond. Find out who the players are in our 1995 Educational Program, "Who's On First?".

Everything the CMS staff, Councils, Committees and Task Forces do is determined by resolutions presented at the meetings of the House of Delegates. Not only that, but each member has an equal opportunity to present resolutions for consideration, to testify before a Reference Committee (or even serve on one) and to have a dramatic impact on the direction CMS will take on important issues in the coming year. The Colorado Medical Society really *is* a member driven organization.

We have lots of educational and fun activities scheduled for you this year, in addition to the business meetings that set CMS policy and drive all our activities for the year.

Look over the enclosed information, select those activities and meetings in which you would like to participate and fill in your registration form. You then may mail it to us (at PO Box 17550, Denver, CO 80217-0550), phone it to us (at 303/779-5455) or even FAX it to us (at 303/771-8657).

Get your registration in quickly. There are limited spaces available for some programs. Notice also that you will need tickets for all meal functions. We must remain fiscally responsible by getting an accurate count of those who will attend these functions.

I encourage you to put on your baseball duds for the reception on Thursday and join us for "Puttin' on the Ritz" at the President's Dinner Dance on Saturday. I look forward to seeing you in Aspen!

Sandra L. Maloney

Brookside Medical Office Leasing

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Denver, Colorado 80221

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- *Easy access to I-25, I-76 and Hwy. 36*
- *Serving Thornton, Northglenn, Westminster and Broomfield*

Physician Integration Phase II & Beyond

A seminar sponsored by the Copic Agency
1:00 pm Saturday, September 9

The presentation will address the legal, business, and practical issues facing the physician today.

Leon B. Harrison, CLU and Gerald A. Neiderman, Attorney, with Faegre & Benson, will be the featured speakers. Any questions concerning the seminar should be directed to Ron Krieger, Copic Agency, 303-779-0044 or 1-800-421-1834.

Call For Nominations

1995

Colorado Medical Society

Certificate of Service Award

The Certificate of Service is the highest award given by Colorado Medical Society in recognition of a physician's outstanding contribution to the constitutional purposes of the Society.

Deadline for receipt of nominations for the 1995 Colorado Medical Society Certificate of Service Award is July 15, 1995. Nominations should be made by letter.

Call For Nominations

A. H. Robins Award

Presented by the Wyeth-Ayerst
Laboratories

1995 Physician Award for Community Service

Criteria for this award are as follows:

1. The recipient must be a physician, licensed within the state of Colorado.
2. The recipient must be living. Awards will not be presented posthumously.
3. The recipient has not been a previous recipient of the award.
4. The recipient has compiled an outstanding record of community service which, apart from his/her specific identification as a physician, reflects well on the profession.

The Colorado Medical Society Certificate of Service Award and the A.H. Robins Award will be presented at the 1995 **Annual Meeting, September 8-10, 1995**, at Aspen, Colorado.

Deadline for receipt of nominations is July 15, 1995.

Nominations for both awards (with supporting information) should be sent to the **Confidential Awards Committee, Colorado Medical Society, PO Box 17550, Denver, CO 80217-0550**

NONCIRCULATING

PERIODICAL

NONCOMPETING

PERIODICAL



